Relationship Centered Care for Caregivers: Long-Term Care Integration

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Abstract

The purpose of this project was to determine if a relationship centered care quality improvement (QI) program based on practicing relationship centered care (RCC) could improve workplace satisfaction and caregiver burden scores for all healthcare providers in a long-term care facility. A sample of all healthcare workers were recruited from a long-term care (LTC) facility in a rural community to participate in this prospective study with a 3-month follow-up. The primary outcome measures were workplace satisfaction and caregiver burden.

Keywords: *nursing home, skilled nursing facility, long-term care facility, quality improvement, caregiver burden, workplace satisfaction*

Relationship Centered Care for Caregivers: Long-Term Care Integration

Provision of healthcare based on the paradigm of patient-centered care has been a goal of healthcare in the United States (U.S.) for more than a decade. The publication of the Triple Aim of Healthcare created by the Institute for Healthcare Improvement (IHI) in 2007 further supported the goals of patient-centered care and adds goals related to population health and the costs of healthcare. The Triple Aim involves "improving the health of the population, enhancing the experiences and outcomes of the patient, and reducing per capita costs of care for the benefit of communities" (Lewis, 2014). Patient centered care is based on the idea of the patient-provider relationship and can be the foundation for relationship centered care (Nundy & Oswald, 2014).

When Beach & Inui (2006) published their work on relationship centered care, the framework was constructed on four principles: "relationships in healthcare ought to include the personhood of the participants, affect and emotion are important components of these relationships, all healthcare relationships occur in the context of reciprocal influence, and the formation and maintenance of genuine relationships in healthcare is morally valuable." The idea of relationship centered care has evolved and can be further defined by four types of relationships: the patient-provider relationship, the relationship with other providers, community relationships and the relationship with self. Relationship centered care is integral to the aim of improving the health of the population because it embraces strengthening of the relationships with the entire health care team, not just the patient and provider (Nundy & Oswald, 2014). Relationship centered care employs the essential characteristics of interdependent relationships necessary to create an enriched environment of care in which the patients and providers needs are addressed (Barbosa et al., 2015).

Workplace Satisfaction

The number of individuals needing placement for long-term care is increasing worldwide while the labor force of nurses is decreasing (Willemse et al., 2015). Direct care workers comprise the largest component of workforce in long-term care (LTC) facilities. The duties of the direct care providers bring them into close interaction with the patients throughout the work day as they assist the residents with the

activities of daily living (Fukuda et al., 2018). This is reflective of the influential role direct care providers play in quality of life and quality of care for their patients.

Inadequate training and education in provision of care in LTC facilities, high workload demands, interpersonal conflicts or non-supportive leadership can contribute to high levels of caregiver stress, burnout, and job dissatisfaction, resulting in compromised quality of care for residents, and ultimately affecting their wellbeing (Fukuda et al., 2018). This will have a major impact on individuals in need of placement in a LTC facility and the availability of potential staff to provide care to these residents (Fukuda et al., 2018).

Annual employee turnover rates in LTC continually increases because nursing staff in general are prone to burnout due to the emotional stress of interacting with the same clients on a long-term basis (Willemse et al., 2015). Research shows lack of job satisfaction is the main reason for leaving a job in LTC (Rokstad et al., 2017).

Job satisfaction is reduced because healthcare providers in the LTC setting feel unappreciated and are dissatisfied about the quality of care they are able to provide (Rokstad et al., 2017). Nurses are most positive towards their job in LTC when they are supported by their organization and colleagues, feel valued, receive thorough education and training, supervision, mentoring opportunities, and appropriate payment (Rokstad et al., 2017). It is essential to find an approach to create a satisfied and sustainable workforce to ensure future residents will be cared for safely and effectively (Rokstad et al., 2017).

Purpose

The purpose of the QI project was to decrease caregiver burden and increase workplace satisfaction in the LTC setting through implementation of an evidence-based curriculum focused on relationship-centered care that has been developed and implemented by the principal investigator (PI) for all healthcare providers in a long-term care facility in North Carolina. The enduring goal was for the program to be integrated into all new hire orientations for all future healthcare providers hired by the facility.

Literature Review

Relationship-Centered Care

Understanding relationship centered care provides insight and understanding on how relationships can influence health care experiences and outcomes (Soklaridis et al., 2016). Relationship centered care is founded on four principles: personhood matters, affect and emotion are important, relationships do not occur in isolation, and maintaining genuine relationships is necessary for health and recovery and is morally valuable (Soklaridis et al., 2016). Relationship centered care has been interpreted by Beach and Inui (2006) as delivery of healthcare focusing on the relationship with the patient, relationships with other providers, relationships in the community and relationship with one's self.

Safran et al. (2006) found that relationship-centered theory implemented within an organization and practice is associated with increased quality of care, quality of life for healthcare providers, and improved organizational performance. A relationship centered care approach incorporates an interdisciplinary care model and has been proven to improve workplace satisfaction across all disciplines. Highly functioning care teams have been associated with significantly reduced patient mortality and better functional health outcomes for patients. A high functioning organizational culture exhibits fundamental qualities of facilitative leadership, shared goals and expectations among clinicians, staff and administrators, a context of mutual respect, shared knowledge as the foundation for interactions, and effective conflict management and problem-solving strategies, all based upon the relationship-centered care framework (Safran, et al., 2006).

Caregiver Burden

Caregiver burden can be defined as the strain or load borne by an individual who cares for a chronically ill, disabled, or elderly person (Swezey, 2019). Caregiver burden can also be defined as the extent to which caregivers perceive caregiving has an adverse effect on their emotional, social, financial, physical, and/or spiritual functioning (Adelman et al., 2014). The duties associated with provision of care in the LTC setting can be affected by a number of factors, to include the health status of both the caregiver and the patient (Bekdemir & Ilhan, 2019).

Caregiver burden is observed as a multidimensional concept containing objective and subjective elements (Adelman et al., 2014). Objective elements consist of items related to the nature and time consumption of fulfilling tasks, while subjective elements develop from perceived emotions, along with psychosocial stressors. The aging population, increased number of individuals living with chronic disease, and lack of support caregivers has increased the prevalence of caregiver burden (Adelman et al., 2014).

In 2004, the U.S. Labor Department's Bureau of Labor Statistics named work in skilled nursing facilities as the second most hazardous job in the country due to the health consequences of employees in this setting. Direct care providers in long term care often experience physical injuries such as musculoskeletal problems and problems with mental health such as depression. The physical and mental health of employees in long term care warrants attention due to the impact on workplace satisfaction, retention of employees and quality of care provided to the residents (Zhang, et al., 2016).

Variables that may contribute to caregiver burden in the LTC setting are physical strain, neuropsychiatric symptoms of patients with dementia, patient-related complexity of care due to multimorbidity, limited time resources, expanded need for documentation and conflicts with colleagues or relatives (Seidel & Thyrian, 2019). Caregivers have been found to age faster, demonstrating the effects of caregiver burden go beyond temporary distress and cause permanent emotional and physical consequences (Swezey, 2019).

Acknowledgement of the detrimental effects on mental health of caregivers has been recognized for many years but the reality of concurrent physical health consequences are now being recognized. It has been known that caregiving can have harmful mental health effects for caregivers, but it is now known that caregivers can have serious physical health consequences (Family Caregiver Alliance [FCA], 2016). Approximately 17% of caregivers feel their health in general has worsened as a result of their caregiving responsibilities. Caregivers who provide care for individuals with dementia risk compromising their immune system up to three years after their caregiving experience ends, increasing the chance of developing a chronic illness (FCA, 2016).

Chen et al. (2015) found that caregiver burden can be caused by the caregivers' inability to cope appropriately in a stressful situation. Caregivers' coping behaviors are strongly associated with psychological reactions. High levels of caregiver burden are associated with the use of emotion-focused coping strategies. Emotion-focused coping strategies are an individual's attempts to control one's emotional response to a stressful situation. The study also found that caregivers' coping behaviors are strongly associated with psychological reaction. How caregivers subjectively assess their circumstances impacts the decisions they make about providing care, seeking assistance, and continuing in the caregiving role. Positive coping strategies allow the caregiver to manage or change stressful circumstances and control emotional responses to stressors. Interventions aimed at improving positive coping strategies have been shown to be successful in reducing caregiver burden, but no intervention has been shown to be effective in reducing negative coping strategies such as avoidance, wishful thinking, and self-blame (Chen, et al., 2015).

Workplace Satisfaction

Job satisfaction is defined as how much employees favor or disfavor their work. Job satisfaction is influenced by the work environment and personality of employees within the organization. Studies have shown a correlation between job satisfaction and the degree of staff turnover in LTC facilities (Castle et al., 2006).

Across all healthcare settings there is a widespread shortage of all levels of nursing care providers and high turnover rates. In the residential LTC setting staff turnover rates range from 40-500% (Hoben et al., 2015). Donoghue et al., (2010) observed nursing assistants (NA) had the highest employee turnover rate at 74%, and registered nurses had the next highest rate at 56.1%. The U.S. population continues to age, the demand for caregivers in the LTC setting continues to rise, but there remains a national shortage of healthcare providers in these settings (Castle et al., 2006). There are various factors correlated to staff turnover rates, with lack of job satisfaction being the most cited (Hoben et al., 2015).

Job satisfaction has also been found to be positively associated with quality of resident care in these facilities, with increased mortality in long-term care facilities having an effect on decreased job

satisfaction among direct care providers (Castle et al., 2006). Not all dissatisfied healthcare providers decide to leave their job, but dissatisfaction can impact their work, relationships with their coworkers, and the quality of resident care delivered. Dissatisfied healthcare providers often exhibit signs of unreliable work ethic, such as tardiness and unscheduled days off. Staff who are dissatisfied also show greater aggression towards their coworkers and residents. Job dissatisfaction is associated with reduced quality of resident care, resident quality of life, and reduced ability of an organization to change (Hoben, et al., 2015).

Overall, healthcare providers tend to remain employed in LTC organizations that provide a good work atmosphere by providing opportunities for educational development, appropriate support from their peers and managers, and readily available resources to aid in the provision of quality care to residents (Eltaybani et al., 2018). Their work found that work environments that provide these variables have been shown to increase healthcare providers' organizational and psychological empowerment, commitment to the organization, and decrease job strain.

A study from Barbosa et al. (2015) reported group cohesion, better emotional management, and self-care awareness as three major themes after an educational intervention incorporating emotional and motivational characteristics was implemented in a small study. An educational intervention integrating emotional and motivational aspects can safeguard healthcare provider's emotional, physical, and mental health in the workplace through a relationship centered care model. Therefore, individuals who participated in the intervention found that their well-being is closely associated to the well-being of their patients. Healthcare providers who are unable to take care of themselves using healthy strategies will fail at delivering wholesome quality care to their patients (Barbosa et al., 2015).

Methods

This was a three-month, quality improvement project implementing a program designed to improve workplace satisfaction in the context of a doctorally-prepared nurse practitioner student designed and managed project. The project was based on relationship centered care and conducted in a long-term

care facility in rural North Carolina. The residential facility has units for assisted living, skilled nursing care and memory care. All direct care employees were eligible to participate.

Due to restrictions related to the COVID-19 pandemic, all aspects of the project were presented using online technology. The pre-intervention and post-intervention surveys were distributed to participants using a secure online survey provider. The facility stakeholder facilitated presentation of the RCC program created by the principal investigator (PI), using voice over internet protocol (VOIP)**.**

Participants

This facility employs direct care providers around the clock, seven days a week and 52 weeks per year. The PI for this project worked closely with the facility stakeholder to distribute recruitment information to all direct care providers on all the shifts. Participation in the project was voluntary and refusal to participate or answer any particular question did not result in any penalty.

Measures

The goal of this QI project was to determine the impact of a program of relationship centered care on caregiver burden and workplace satisfaction on the direct care employees at a LTC facility. Two tools were utilized to measure outcomes: the Caregiver Burden Index (CBI) and the Workplace Satisfaction survey.

Caregiver Burden Index

The CBI is an evidence-based quantitative tool for assessing caregiver burden that is copyrighted by the original author. The PI engaged in electronic communication with the author, Dr. Mark Novak of San Jose State University, and obtained permission to modify the tool for use in this project, making it more applicable to the LTC setting. The tool is based on five variables: time dependency, emotional health, physical health, social relationships, and personal development. The tool uses scores of 0 to 4 on an ordinal scale for each question. A higher score is reflective of higher caregiver burden (see Appendix A).

A study was performed measuring the validity and reliability of the CBI instrument and results showed this instrument fits data better than a single instrument model and revealed high internal

consistency reliability (Valer et al., 2015). This tool is a resource to tailor interventions for improving caregiver burden.

Workplace Satisfaction

To measure workplace satisfaction, the Provider and Staff Satisfaction Survey was administered pre- and post-intervention (see Appendix B). This tool is a quantitative measure of workplace satisfaction based on six questions. The survey asks participants to rate the work environment based upon coworkers, level of respect received by all individuals including medical and non-medical staff, communication and cooperation within team members, attitude and moral of coworkers, person attitude and morale, and if participants would recommend bringing a loved one to the facility for care. The survey is divided into scores of 1 to 10 using an ordinal scale, with one being the lowest level of satisfaction to 10 being the highest.

There have been limited studies proving the reliability or validity of the workplace satisfaction survey. Instead this tool gives a better understanding of factors which have the most influence on workplace satisfaction and how positive changes can improve workplace satisfaction (Al-Abri & Al-Balushi, 2014).

Procedures

This QI project was initiated using an evidence-based curriculum focused on RCC that was developed and implemented by the PI for all healthcare providers in a long-term care facility in North Carolina. The curriculum of RCC was based on the four principles: 1) relationship with the patient, 2) relationships with other providers, 3) relationships in the community and 4) provider's relationship with himself/herself and educate staff about how to grow and nurture these relationships. Due to current COVID-19 restrictions, the RCC training program was a remote presentation through narrated Microsoft PowerPoint™. All participants were asked to complete a pre-intervention survey prior to accessing the RCC program. Only those participants who completed the pre-intervention survey and the RCC program were asked to complete the post-intervention survey to ensure comparison data was accurate and reliable.

All project participants engaged in the same intervention by completing the CBI survey tool and the Provider and Staff Satisfaction Survey prior to and following the RCC training. The surveys were administered to participants via SurveyMonkey™ and their responses were recorded anonymously. To ensure congruence with pre- and post-surveys, participants were asked to create a unique identification code that was free of personal identifiers.

The PI maintained follow-up with the stakeholder and participants periodically throughout the three-month period to address questions, assess engagement in the project, and minimize the risk of attrition.

Ethical Considerations

This QI project was reviewed and approved by the Lenoir-Rhyne University Institutional Review Board (IRB). Participation was voluntary and participants had the right to withdraw at any time without consequence or prejudice. Informed consent was a single signature consent for online participants from a template available on the Lenoir Rhyne University IRB website and modified for specificity to this project. The informed consent contained information regarding the project's purpose, risks, benefits, participant's rights, and confidentiality.

As an online participant, there is a risk of intrusion, however small, by outside agents (i.e., hacking), therefore the possibility of being identified exists. SSL encryption on SurveyMonkey™ was enabled so that sensitive data was protected as it moved along communication pathways between the respondent's computer and the SurveyMonkey™ servers. This helped ensure any data intercepted during transmission could not be decoded and individual responses could not be traced back to an individual respondent. The IP address tracking option was disabled to make the survey anonymous. Only the PI and the project committee chairperson had access to the SurveyMonkey™ account.

Research participants were given contact information for community counseling services on the informed consent in case their participation in the research caused any personal concerns or feelings of discomfort. The contact information for the PI was also available, along with the contact information for

the Chair of the Lenoir Rhyne University IRB, so any questions or concerns that may have arisen from the project participant could be addressed at any time.

The data was collected and stored using the Intellectus™ Statistics program. A duplicate data set will be stored on a password-protected external drive to ensure safety in the event of damage to the original information. Data will be stored for five years after project completion and then destroyed.

There was no funding for this project. The RCC training was a system change for this facility. The comprehensive curriculum, training materials and voice over internet protocol (VOIP) programs will be retained by the facility for use during orientation for all new employees in the future.

Analysis

The restrictive rules regarding isolation precautions, the unusually high employee turnover rates and increased burden of care for remaining employees at the facility secondary to the COVID-19 pandemic, led to limited participation in the project by employees. Four providers completed the pre-intervention surveys, and two providers completed the RCC training and post-intervention surveys. Due to lack of response no qualitative themes could not be identified and analyzed. The providers who did complete the relationship centered care QI program reported positive outcomes in improvement of caregiver burden and workplace satisfaction (see Appendix C).

Discussion

The COVID-19 pandemic has affected the lives of millions of people around the globe and been declared by the World Health Organization (WHO) as a global emergency worldwide (Irshad et al., 2020). As COVID-19 shut down the world in a matter of days, healthcare workers courageously stepped forward to battle the pandemic. The exponential increase in COVID-19 patients has produced heavier workloads for healthcare providers, to include the direct care providers in LTC facilities. Employee turnover rates has placed heavier workload burdens on continuing employees. The shortage of personal protective equipment has contributed to employee vulnerability to COVID-19 (Irshad et al., 2020). Consequently, the effects of COVID-19 have placed increasingly high levels of physical and psychological burden onto these healthcare workers causing many to revisit their career choices.

While this project was unsuccessful due to lack of employee participation, the RCC program and the utilization of the CBI and Workplace Satisfaction Index will eventually become a system change for the facility. The LTC facility will not currently implement the RCC training for orientation of new employees due to gaps in current employment, to include loss of the facility clinical educator. The organization plans to fill this position and will then resume utilization of the RCC program for orientation when that position is filled.

The two project participants who completed the intervention endorsed the project, stating the emphasis on building and maintaining relationships in the RCC program helped during the SARS-CoV-2 outbreak, because as the work environment evolved into crisis mode, staff relied on one another and relationships became more significant than prior to the SARS-CoV-2 outbreak. Project participants who completed the QI project report their relationships with their peers and patients were the primary motivator to keep them involved throughout the project.

Participants also report that they have maintained employment at the LTC facility throughout the SARS-CoV-2 outbreak because of their relationships with their peers and patients along with a sense of responsibility to uphold their expected obligations within the organization. One of the project participants that completed the QI project reports they resigned from their position due to circumstances outside of work. Due to the anonymity of the project, the PI was unable to identify other research participants who partially completed the QI project.

Limitations

Since the onset of the pandemic from COVID-19 there has been a larger impact on LTC facilities than with any other population group. Long-term care facilities nationally and internationally have reported high levels of outbreaks and deaths from COVID-19 (Thompson et al., 2020). These outbreaks affect not only vulnerable residents but healthcare workers as well.

During discussion with the Clinical Coordinator of the LTC project site, several topics emerged to explain the lack of participation by the LTC facility employees, to include timing of implementation during the SARS-CoV-2 outbreak at the facility. Employee absenteeism related to illness and burnout was

markedly increased during the time of implementation. The organization had entered crisis mode and employee turnover rates were extremely high during the implementation process, limiting employee participation and the ability to gather data. The PI was unable to obtain information on turnover rates for the facility in order to compare turnover rates prior to the COVID-19 outbreak at the facility.

Other limitations include the requirement for project participants to complete the RCC program on their own time. The program took approximately 45 minutes to complete. Depending on the employee's patient workload and responsibilities and responsibilities outside the work environment, few were able to fully participate in the RCC project.

Outcomes were based on participant responses, thus are subject to bias. Project participants were only followed for three months after viewing the RCC program and utilization of some components of the RCC program may have diminished over time, even after completion of the program.

Reflection

Creating, implementing, and disseminating a Doctor of Nursing Practice (DNP) QI project during a pandemic was challenging. The initial aim of the project was exciting and motivating, with hopes of bringing innovation to the provision of care of the aging population. Unfortunately, the SARS-CoV-2 virus not only had an impact on the LTC facility and its employees who the QI project was focused on serving, but to the PI and future healthcare providers who want to pursue a career in the LTC setting. It is gratifying to know those who did complete the QI project reported improved caregiver burden and workplace satisfaction and disappointing to know other employees will not have an opportunity to participate and learn about relationship centered care.

There was hope during the time of implementation that despite the major changes the facility was undergoing due to the SARS-CoV-2 outbreak that the RCC program would be beneficial and provide healthcare providers in the LTC setting the appropriate tools needed to endure the pandemic and remain unified as an organization. Looking to the future, it is hoped that the RCC curriculum can be implemented and proven an accepted and effective quality improvement for all LTC facilities. Future practice as a

nurse practitioner in the long-term care setting will enable implementation of the project and analytic proof of the validity of the RCC curriculum.

Conclusion

Going beyond healthcare providers' knowledge and instrumental skills to address their emotional and relational skills is vital to the increasing workplace satisfaction and reducing caregiver burnout. Relationship centered care captures the importance of interdependent relationships, enhances workplace environment, and addresses the needs of employees assuring high quality care will be provided to all patients (Barbosa et al., 2015). Quality improvement strategies were employed to create a RCC curriculum based upon evidence-based practice for all healthcare providers in the LTC setting. The aim was to improve workplace satisfaction and decrease caregiver burden for all healthcare providers at a rural LTC facility and, although this QI project was unsuccessful, future projects based on this program are indicated to improve caregiver burden and workplace satisfaction for care providers.

This project highlighted recommendations for future research to include implementation of virtual interventions post-pandemic and continued provider education on relationship centered care. The recommendation to implement virtual intervention post the COVID-19 era requires healthcare systems to acquire and support accessible, affordable, and flexible online learning protocols (Dhawan, 2020). Virtual interventions are required to support social distancing and in return reducing COVID-19 exposure and transmission. Virtual learning is considered to be a relatively inexpensive mode of education and allows flexibility to accommodate to the learners' schedule.

The second recommendation is to continue educating providers on relationship centered care. This project showed that the providers who did complete the RCC curriculum had improved workplace satisfaction and caregiver burden. Healthcare professionals have been reluctant to involve themselves in QI interventions, especially in phases of organizational instability (Pannick et al., 2016). Change fatigue, or resistance to new initiatives can be combated through identification of elements that will optimize QI intervention acceptance. These elements consist of allotting project participants protected time for intervention training and ensuring the QI intervention is applicable to the project setting. Further research

needs to be completed post-pandemic in the LTC setting once staffing has stabilized, major changes following the pandemic are adopted, and providers can offer their full attention to the RCC intervention.

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Appendix A
Caregiver Burden Inventory
(Novak and Guest, 1989)

The Case Manager will administer the inventory by reading the statement and marking the responses. Choose the number that best represents how often the statement describes your feelings.
0: Never 1: Rarely 2: Sometimes 3: Quite frequently 4: Nearly always

Client Name:

Caregiver Name:

Date:

Time Dependency Items	
My patients need my help to perform many daily tasks	⓪①②③④
My patients are dependent on me	⓪①②③④
I have to watch my patients constantly	⓪①②③④
I have to help my patients with many basic functions	⓪①②③④
I don't have a minute's break from tending to my patients needs	⓪①②③④

Emotional Health Items	
I feel embarrassed over my patients' behavior	⓪①②③④
I feel ashamed of my patients	⓪①②③④
I resent my patients	⓪①②③④
I feel uncomfortable when I have fellow coworkers around	⓪①②③④
I feel angry about my interactions with my patients'	⓪①②③④

Physical Health Items	
I'm not getting enough sleep	⓪①②③④
My health has suffered	⓪①②③④
Care giving has made me physically sick	⓪①②③④
I'm physically tired	⓪①②③④

Development Items	
I feel that I am missing out on life due to work responsibilities	⓪①②③④
I wish I could escape from this situation	⓪①②③④
My social life has suffered	⓪①②③④
I feel emotionally drained due to caring for my patients	⓪①②③④
I expected that things would be different at this point in my life	⓪①②③④

Social Relationships Items	
I don't get along with fellow coworkers as well as I used to	⓪①②③④
My care giving efforts aren't appreciated by others in my organization	⓪①②③④
I've had problems with my coworkers (or other significant relationship)	⓪①②③④
I don't get along as well as I used to with others	⓪①②③④
I feel resentful of other coworkers who could but do not help	⓪①②③④

Scores near or above 36 indicates a greater need for respite and other services.
It is important to seriously look at any item on the burden scale where the answer was scored as a 3 or 4 ('quite frequently' or 'nearly always'). If you have a 3 or 4 as an answer, give careful thought about why the caregiver scored so high on the question and see if you can find a way to reduce the stress.

Appendix B

Workplace Satisfaction Index

Please respond to the following questions using a scale of 1 to 10 (with 1 being lowest rating and 10 the highest rating).

1. How would you rate your team as a place to work on a scale of 1–10?

   1 2 3 4 5 6 7 8 9 10

2. How would you rate the level of courtesy and respect with which you are treated by people at all levels, including medical and non-medical staff?

   1 2 3 4 5 6 7 8 9 10

3. How would you rate how well people you work with cooperate, communicate and help each other out?

   1 2 3 4 5 6 7 8 9 10

4. How would you rate other people's attitudes about working here, in other words, their morale?

   1 2 3 4 5 6 7 8 9 10

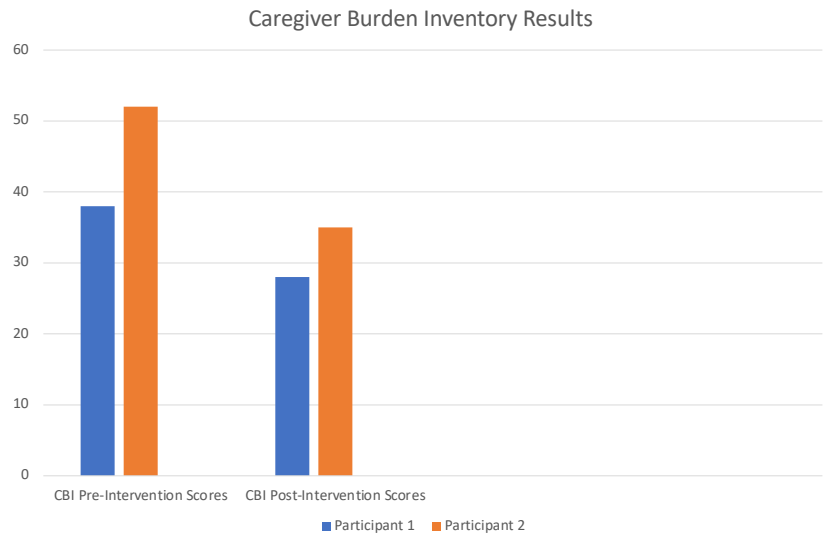
5. How would you rate your own attitude about working here, in other words, your morale?

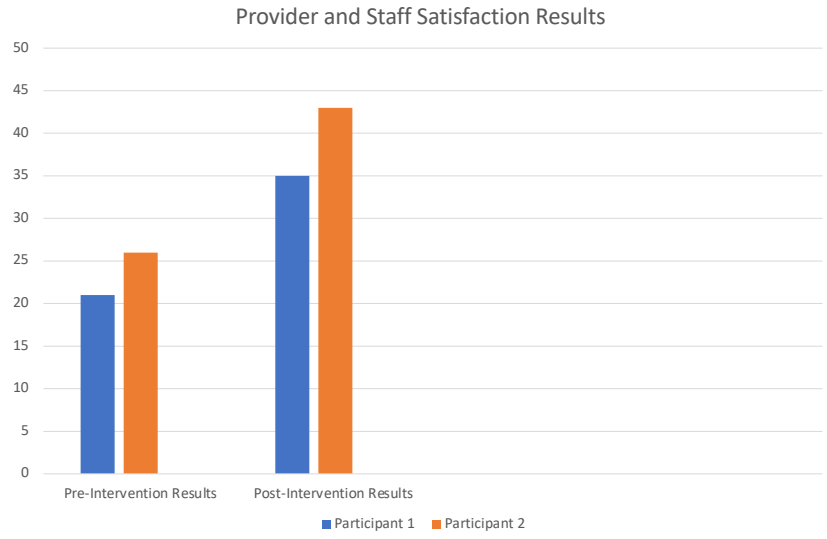
   1 2 3 4 5 6 7 8 9 10

6. Would you recommend your team as a place for your loved ones to come for care?
   (1 = would not recommend → 10 = highly recommend)
   1 2 3 4 5 6 7 8 9 10

Comments:

Appendix C


Caregiver Burden Inventory Results
60
50
40
30
20
10
0
CBI Pre-Intervention Scores
CBI Post-Intervention Scores
Participant 1
Participant 2


Provider and Staff Satisfaction Results
50
45
40
35
30
25
20
15
10
5
0
Pre-Intervention Results
Post-Intervention Results
Participant 1
Participant 2