

A CHANGE INITIATIVE TO PREVENT CRITICAL CARE NURSE BURNOUT
IMPLEMENTING A SACRED PAUSE FOLLOWING PATIENT DEATH

A Doctor of Nursing Practice Project Report

by

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This Doctor of Nursing Practice Project Report meets the standards for scope and quality of Texas A&M University-Corpus Christi College of Nursing and Health Sciences and is hereby approved.

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August 2021

DEDICATION

This work is a tribute honoring caregivers who have committed to serving others and being a healing presence to those around them. I would also like to take a moment to dedicate this work to the lives of those we have loved and lost. A special thank you to my late Grandmother Minnie Mazoch, late Grandfather Edmond Raesz, and my aunt Patricia Raesz. They required medical care and are the ones who most influenced my decision to become a nurse.

ACKNOWLEDGEMENTS

I want to express my sincere gratitude towards my family for their encouragement throughout my lifelong learning journey and who continue to support my commitment to the patients and nursing profession. My family has been by my side every step of the way. They are an inspiration to me and continue to support me in following my calling.

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Lastly, I would like to thank my fellow graduating cohort, my nursing mentor that I have worked with on the front line, in other roles, and who has continued to support me in my nursing journey, and a final thank you to my healthcare organization, leadership and front-line caregivers.

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ABSTRACT

Background: Critical care nurses are increasingly challenged by the complex work environment of the critical care unit. The nature of a critical care nurse's job can be especially stressful because of the high patient morbidity and mortality, challenging daily work routines, and regular encounters with traumatic and ethical issues. Burnout concerns are particularly important when critical care nurses serve patients who die under their care, which can exacerbate general burnout. **Purpose:** This evidence-based change initiative aims to prevent burnout and thereby promote resilience in the critical care nurse by using an intentional sacred pause following a patient death. **Methods:** This change initiative project is a pre-test/post-test design. Burnout was measured pre-and post-intervention (the sacred pause) with the intention to prevent critical care nurse burnout and thereby promote nurse resilience. The Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS-MP) was used to measure nurse burnout. **Conclusion:** The MBI-HSS-MP inventory scores were similar on both pre-and post-intervention assessments indicating prevention of nurse burnout. This evidence-based practice change initiative was well received by the staff members in the hospital and demonstrated clinical significance. Participation in the intervention was documented. The use and progressive implementation of the sacred pause following patient death was naturally implemented by the nurses. Critical care nurses are a vulnerable population susceptible to burnout. Further research around multi-modal health-promoting interventions such as the sacred pause will be beneficial for this population. Supporting critical care nurses to adopt health-promoting behaviors may promote resilience and prevent the risk of burnout that often results in many nurses leaving the profession.

A Change Initiative to Prevent Critical Care Nurse Burnout
Implementing a Sacred Pause Following Patient Death

INTRODUCTION

Burnout in critical care nurses is a public health crisis (Shanafelt et al., 2018). Critical care nurses are increasingly challenged by the complex work environment of the critical care unit, which results in 25%-80% of critical care nurses experiencing mild to severe burnout (Arrongante & Aparicio-Zaldivar, 2017). Burnout leads to nurses leaving their job or the nursing profession entirely (Agency for Healthcare Research and Quality [AHRQ], 2019). The cost of organizational turnover among registered nurses (RNs) is estimated to be 1.2 to 1.3 times an individual's salary (estimated annual total cost of \$82,000-\$88,000 per RN) (Dyrbye et al., 2017). Burnout may also indirectly increase other health care costs resulting from increased errors, malpractice claims, absenteeism, and lower productivity (Dyrbye et al., 2017). Further, burnout can lead to increased adverse patient events or emotional or psychological distress in the critical care nurse (Tawfik et al., 2019). The potential for burnout is particularly concerning when critical care nurses serve patients who die under their care, which can exacerbate general burnout due to grief.

The purpose of this evidence-based change initiative was to prevent perceptions of burnout and thereby promote resilience in a specific group of critical care nurses by using an intentional, sacred pause following a patient death. The sacred pause honors a patient and the critical care nurse, along with the critical care team (Bartels, 2014). It is a 15-30 second period of silence shared by the critical care nurse and team after a patient death (Bartels, 2014). The sacred pause provides closure to the relationship between the critical care nurse, critical care team, and the patient, preparing the team to care for other patients (Bartels, 2014).

Background and Significance

Critical care nurses are at a higher risk for burnout, with 20% reporting feeling disengaged (Brusie, 2019). The nature of a critical care nurse's job can be incredibly stressful because of the high patient morbidity and mortality, challenging daily work routines, and regular encounters with traumatic and ethical issues of life or end-of-life decisions (Moss et al., 2016). These stressors are prevalent in the Long-Term Acute Care (LTAC)/critical care environment and are not commonly associated with nursing in other areas of healthcare (Chuang et al., 2016).

Although nurses in other areas of health care, experiencing burnout, such as procedural, medical-surgical, and outpatient clinical areas, burnout rates in critical care settings are among the highest (Chuang et al., 2016). Community health nurses experience burnout at a rate of 8%, general practice nurses at 8%, and critical care nurses at an unusually high rate of 20% (Chuang et al., 2016). According to Arrogante and Aparicio-Zaldivar (2017), in a study of 52 critical care professionals, the estimated prevalence of burnout ranged from 25%-80% of the sample with a severity ranging from mild to severe burnout. Burnout can be defined as an emotional and behavioral impairment brought on by exposure to high levels of occupational stress and has been described as a combination of three factors: emotional exhaustion, depersonalization, and lack of personal accomplishment (Van Mol et al., 2015). Critical care nurses' daily tasks often include the risk of committing serious or even fatal errors leading to patient mortality (Arrogante & Aparicio-Zaldivar; Firth, 2019). Such risks create an underlying tension which can affect them physically and mentally (Arrogante & Aparicio-Zaldivar; Firth, 2019). Moreover, poor coping habits may lead to unhealthy coping mechanisms such as drug and alcohol abuse, depression, post-traumatic stress disorder, and even suicidal ideation (Arrogante & Aparicio-Zaldivar, 2017; Firth, 2019). While burnout does not directly lead to the death of critical care nurses, it may lead

them to question why they became a nurse and may cause them to leave the profession altogether (AHRQ, 2019).

The cost of nurse turnover has a significant financial impact on hospitals worldwide (NSI Nursing Solutions Inc. [NSI], 2020). According to NSI (2020), the average cost of turnover for a critical care bedside registered nurse (RN) is \$44,400 and ranges from \$33,300 to \$56,000 resulting in the average hospital losing \$3.6 million – \$6.1 million annually (NSI, 2020). Each percentage decrease in RN turnover rate could save the average hospital an additional \$306,400/year (NSI, 2020). To prevent the potential for burnout, it is imperative that critical care nurses become aware of circumstances that contribute to burnout and learn health-promoting techniques and interventions to use as coping mechanisms when faced with stressful events (Dyrbye et al., 2017; Jackson et al., 2018).

Review of the Literature

Practice gaps arise when hospital leadership fails to identify pertinent and effective interventions to specifically address particular nursing staff issues (Mealer et al., 2017). Intentional resilience techniques specifically address the needs of critical care nurses after experiencing a patient death (Kapoor et al., 2018). Grabbe et al. (2020) explained a need for stress management interventions through organizational empowerment and individual resiliency skill training for critical care nurses. Gaining an understanding of the barriers and concerns specific to the unit and the critical care nurse is especially important when choosing an intervention that supports resiliency and prevents burnout (Mealer et al., 2014; Mealer et al., 2017). Resilience training embedded in practice rituals that are unit-specific have been shown to prevent burnout and promote resilience (Mealer et al., 2014; Mealer et al., 2017). The intentional

sacred pause is a resilience-building intervention demonstrated to prevent or decrease burnout related to the effects of patient mortality on nurses in acute care settings.

Collectively, studies show personal resilience training in critical care nurses is effective in preventing or decreasing burnout (Delaney, 2018; Grabbe et al., 2020; Kapoor et al., 2018; Mealer et al., 2014; Mealer et al., 2017; Sarazine et al., 2020). Delaney (2018) found training critical care nurses with mindful self-compassion interventions and promoting on-the-job protective factors against burnout significantly enhanced resilience ($p=.01$). Sarazine et al. (2020), found training on mindfulness and resiliency in 52 critical care nurses effectively reduced burnout ($p=.03$) and perceived levels of stress ($p=.01$). At six months, the study showed an increased perception of mindfulness ($p = .04$), personal accomplishment ($p = .04$), and decreased emotional exhaustion ($p = .05$) in the sample (Sarazine et al., 2020).

In another study by Montross-Thomas et al. (2016), organizations benefitted from providing training and support for personalized rituals among team members, especially the new staff who may be at greater risk for burnout. Montross-Thomas et al. (2016), surveyed 390 staff members across 38 states investigating the role of personally meaningful rituals in increasing compassion and decreasing burnout. The sample consisted of hospice staff and volunteers with an average of nine years' experience in hospice and palliative care (Montross-Thomas et al., 2016). The majority (71%) of these 390 staff members reported using personally meaningful rituals after the death of their patients to help them cope (Montross-Thomas et al., 2016). Those who used rituals also demonstrated significantly higher compassion satisfaction ($p= \leq .01$) and significantly lower burnout ($p= \leq .05$) as measured by the Professional Quality of Life scale (Montross-Thomas et al., 2016). These findings support burnout can be prevented or reduced by

promoting resilience and implementing mindfulness practices such as the intentional sacred pause.

Description of the Problem

The project site is a free-standing hospital with two units and is a part of a large not-for-profit integrated healthcare system. The project took place on the 25-bed LTAC unit. In the fiscal year 2020, the LTAC unit had 216 admissions, 221 discharges, 6,711 patient days, an average daily census of 23, and an average length of stay of 23.5 days. This unit was experiencing turnover of long-standing employees and an increased number of patient deaths. The COVID-19 global pandemic exacerbated turnover and number of patient deaths. Voluntary and involuntary turnover for the fiscal year 2020 was ten nurses, and the first two quarters of fiscal year 2021 were three nurses. The total number of patient deaths for the fiscal year 2020 was six, and the first two quarters of the fiscal year 2021 were nine. This data supported the need for an organizational assessment of factors related to excess death and potential related burnout specific to this unit.

The organizational assessment included interviews of front-line bedside critical care nurses. The discussion included any actions taken following the patient's death, such as debrief sessions, and follow-up. On this unit, it was reported that minimal to no actions were taken following a patient's death. For the assessment, critical care nurses on the unit were observed and interviewed following a patient death. One nurse reported, "had we had a minute to stop and breathe after, it would have helped" (Personal Communication, July 22, 2020). The charge nurse reported they had an informal debriefing later in the medication room to discuss the event, but it was not intentional and may not have included all involved in the patient's care and death. Furthermore, the nurses never had a moment to stop and acknowledge what just happened and

the impact each of them had made on the patient and vice versa. However, it was evident the staff wanted the current practice to change. The nurses voiced agreement that a pause in time would allow the critical care team to honor the life of the patient after they die, as well as the critical care nurses' efforts during their time with the patient throughout the admission.

The organizational assessment supported the need for an evidence-based intervention or change. Hospital leadership and LTAC staff indicated support of this evidence-based change initiative. The goal was to implement an evidence-based practice change initiative to prevent burnout and thereby promote resilience in the critical care nurse. The evidenced-based change initiative was to naturally implement the sacred pause following a patient death as an intervention on this project unit. The organizational mission and healing work environment will facilitate the ability to be successful in bringing about and sustaining this change.

Theoretical Frameworks

The Plan-Do-Study-Act (PDSA) theoretical guiding framework, developed in the 1920s by Shewhart, is a four-step model to carry-out a change initiative and was the overarching guide for the project (Institute for Healthcare Improvement [IHI], 2020) (See Appendix A). The cyclical model was the first cycle of the project. This project was guided by the PDSA commonly used upon implementation of an evidence-based change initiative such as this one, and is more specifically guided by Kurt Lewin's Change Theory (Shirey, 2013).

Lewin's Change Theory is a three-stage model of change that requires prior learning to be rejected and replaced (Shirey, 2013). The change theory by Lewin (concepts: unfreezing, change, freezing) helps direct evidence-based practice change initiative implementation because it recognizes the need to change the old practice pattern (Shirey, 2013). The old practice pattern was lack of an intervention post-patient death (unfreeze stage) (Shirey, 2013). The new practice

pattern was adding an intentional sacred pause following a patient death with educational guidance and a follow-up plan (change stage) (Shirey, 2013). The final stage in Lewin's Change Theory is refreezing the change (Shirey, 2013). If the change is determined to be successful, the practice is refreezing. If unsuccessful or other changes are needed prior to refreezing, the change team must go back to the planning stage of the PDSA cycle and start a second cycle. (See Appendix A and Appendix B). Lewin's Change Theory provided a valuable framework for adopting the new practice in the hospital unit's processes, the sacred pause. The model started with initially only a few staff, critical care nurses being open to the idea and adopting the intervention. As the gatekeepers/change agents helped 'spread the word,' more and more people became open to it. Over time the idea has become diffused throughout the rest of the bedside staff and even naturally implemented on the other unit, until a point of saturation was reached. The results noted minimal burnout, resilient staff, and positive staff satisfaction. The sacred pause was naturally implemented on this unit. Before refreezing, it is recommended to conduct another cycle of PDSA secondary to the short duration of the change stage for the purposes of this project.

Purpose Statement and Specific Aims

The purpose of this evidence-based change initiative was to prevent the critical care nurse's perception of burnout and thereby promote resilience in a Central Texas hospital by instituting an intentional sacred pause following a patient death. The clinical question guiding this evidenced-based project was: In critical care nurses in a Central Texas LTAC hospital, does implementing a personal resilience technique influence perceptions of burnout as compared to before training?

Aim One

The goal was to prevent burnout in the critical care nurses of the LTAC unit. The specific goal was to prevent feelings of burnout as evidence by average scores less than three on emotional exhaustion, less than three on depersonalization, and greater than three on personal accomplishment subscales of the MBI-HSS-MP post-intervention or to see improvement by at least 10% in one of the dimensions of the three subscales, emotional exhaustion, depersonalization, and personal accomplishment of the MBI-HSS-MP from pre-intervention to post-intervention (Van Mol et al., 2015).

Aim Two

The goal was to increase the use and progressive implementation of the sacred pause naturally following patient death. Following the death, the charge nurse recorded who participated in the sacred pause on a documentation form and returned it to the nurse manager. The first measurable goal was for 100% of patient deaths in the unit to be followed by a sacred pause. The second specific goal was for at least 50% of the critical care nurses working on the unit to participate in the sacred pause at the time of death.

This project aligns with the American Association of Colleges of Nursing (AACN) (2006) Doctor of Nursing Practice (DNP) essentials, specifically the DNP essential III clinical scholarship and analytical methods for evidence-based practice, improving the care of critical care nurse practices, to prevent burnout and promote resilience in the critical care nurse (AACN, 2006). According to the American Organization of Nurse Executives (AONE) and the American Organization for Nursing Leadership (AONL) (2015), competencies are associated with knowledge of the health care environment; also, the project integrates the essential to monitor and address nurse-sensitive outcomes and satisfaction indicators.

METHODS

Project Design

This project was an evidence-based, practice change initiative to prevent burnout and thereby promote resilience in the critical care nurse by using an intentional sacred pause following a patient death. This change initiative project was a pre-test/post-test design. Burnout was measured pre-and post-intervention (the sacred pause). The MBI-HSS-MP was used to measure nurse burnout.

Prior to implementation of the sacred pause, the MBI-HSS-MP was administered. Education sessions on the process of conducting a sacred pause were provided to each shift. Reminders on the process were printed on cards for all staff to wear with their badges. The implementation of the sacred pause was conducted by the charge nurses. Providing reminders in the form of ‘badge buddies’ in this has been shown to be effective (Bastable, 2017). The MBI-HSS-MP was administered following the implementation.

The project was conducted at a LTAC facility in Central Texas, serving surrounding rural communities. The culture of the hospital setting is one like a small family. The staff in this hospital are a tight-knit group; most often, staff will voice, like family. The staff in the building often speak about the hospital culture and environment and refer to this facility as team continuing care hospital (CCH) “team CCH”. Hospital leadership and LTAC staff also voiced their desire to support this evidence-based change initiative and promote nurse health through daily initiatives by starting daily shift huddles with a positive and inspirational message and promoting staff to use the organizational portal that promotes healthy initiatives. Staff participation in a program called Thrive is another health-promoting activity for mind, body, and spirit. The promotion of a healing work environment will facilitate the ability to bring about and

sustain this practice change initiative. Since the goal of this evidence-based practice change initiative is to prevent burnout and thereby promote resilience in the critical care nurse, it is a good fit with the existing organizational culture.

There were risks and threats that could potentially affect the implementation of this practice change initiative. They were the small sample size of critical care nurses since this was a relatively small unit of 48 beds (n=31) and the unpredictable nature of occurrence of patient deaths. Another risk was attrition from the pre-test to post-test. Other potential challenges included the stressors of the COVID-19 global pandemic and the risk critical care nurses would not complete the MBI-HSS-MP inventory with honest answers due to fear of disclosure and privacy compromised. The organizational assessment data showed gaps in practices on this unit and supported the need for critical care nurse training on the sacred pause following a patient death. These factors were mitigated by: completion of staff education to all critical care nurses at the start of the three-month project timeline including charge nurse education, assisting charge nurses with front-line leadership roles, education of staff and other leadership team members to raise awareness. Reminders were sent regarding taking the online surveys including information that the survey included no staff or patient identifiers for confidentiality purposes. Please see the risk assessment Appendix C for facilitators and countermeasures taken to mitigate these various risks.

Participants and Recruitment

This project plan was reviewed by the Texas A&M University-Corpus Christi, and the project site/hospital setting Institutional Review Board (IRB) for project/study classification and received a determination of *Not Human Subjects Research* and permission to proceed as an evidence-based practice change project. (See Appendix D and Appendix E.) Personal Health

Information (PHI) was collected for project purposes only following the execution of a Health Insurance Portability and Accountability Act (HIPAA) Confidentiality Agreement from the facility. (See Appendix F.) A letter of support was provided by the Vice President of critical care services/patient care services of the hospital, agreeing to fully support the project and acknowledge the collection of PHI for project purposes only. (See Appendix G.) In order to protect the participants' confidentiality, all data was deidentified.

A convenience sample was obtained by recruiting all critical care nurses. Critical care nurses were approached one on one at the start of the 90-day project timeline. Participants were excluded if they were not a critical care nurse.

Intervention

This project required education for the nurses to make them aware of the purpose of the change in practice and the process of conducting the sacred pause (Bastable, 2017). Educational materials included a flyer to educate the critical care nurses at their safety huddles and the same information was included in a smaller format for the critical care nurse to wear with their badge as a 'badge buddy' (Di Vincenzo, 2017). (See Appendix H). All informational/educational huddle sessions were compensated at non-productive, non-overtime rates, with an allowance of 15 minutes per session. The last five minutes of the session were provided for questions and answers. Information on the flyer included the rationale for completing the sacred pause following the patient's death. Education to improve understanding and communication among all critical care nurses involved is a crucial element in the unfreezing stage of Kurt Lewin's Change Theory (Shirey, 2013).

The project team was made up of the project director (PD), a nurse manager employed by this hospital, and charge nurses responsible for initiating the sacred pause. In addition, the charge

nurses were responsible for notifying the PD of any deaths and collecting the data before leaving the shift that the death occurred. Participants of the evidence-based change initiative included all day and night shift critical care nurses on the LTAC unit. The number of critical care nurses included and not excluded as participants include a sample size of 31 total individuals. At the start of the 90-day project timeline, January 2021, encouraging participation from all critical care nurses was important. The charge nurses were chosen to carry out this project with guidance and support from the nurse manager. The charge nurses have been chosen as they are identified as the ‘gatekeepers’ of the bedside critical care nurses and because of their open-minded personalities. While this project focused on preventing burnout and promoting resilience in the critical care nurse, it was important to allow all critical care team members to participate in the intervention. Through the inclusion of all, the natural adoption of the sacred pause was promoted while also preventing the risk of silos forming during the change. For the project comparisons, only licensed critical care nurses of the LTAC unit were included in the pre-and post-survey. However, other critical care team members were encouraged to participate in the sacred pause event. Patient deaths included in this project were patients on the LTAC unit that died from February 2021 through May 2021. The sacred pause followed all deaths, expected (comfort care), or unexpected (codes) during the three-month timeframe. Please see the timeline in Appendix I for a visual diagram of the estimated time it has taken to conduct each part of this project, from collecting organizational assessment data to dissemination of results and sustainability.

Data Collection

In January of 2021, all critical care nurses were included in education and participation and completed the MBI-HSS-MP inventory questions via electronic survey. The inventory took

place before the education of staff related to the intervention. An additional critical care nurse characteristics form (Appendix J) was administered along with the MBI-HSS-MP inventory to include information about whether the nurse has participated in a medical alert/code, has the critical care nurse experienced the death of a patient, and an estimated timeframe of years of experience as a critical care nurse. Other descriptive data included RNs or licensed vocational nurses (LVNs) that often care for critically ill patients on this unit.

When a patient death occurred on the unit, the charge nurse was asked to document specified details, which included asking if the sacred pause with the staff was completed, whether the event was a medical alert/code, or was the patient comfort care prior to the death. It was also decided to gather the credentials of other critical care team staff members who participated in the sacred pause because the hospital is small, and team members are like “family.” It has been an unintended occurrence to note if interdisciplinary caregivers from other service lines participate as they see their colleagues participating. A generous amount of time was allotted for data collection to ensure all staff members feel welcomed to participate in the intervention. Additional staff participated outside of the LTAC unit critical care nurse; however, they have not taken the MBI-HSS-MP inventory and did not take it at the end of the implementation phase; however, it is important to note in the results that additional members have participated voluntarily. This is a potential for the next PDSA cycle; ongoing communication of accomplishments and any need for modification was important at this time along with taking steps towards sustainability and plans for improvement to restart the PDSA cycle (IHI, 2020). Please see the post death evaluation form (Appendix K) used to collect additional post-death data. Please see the timeline in Appendix I for a visual diagram of the

estimated time it has taken to conduct each part of this project, from collecting organizational assessment data to dissemination of results and sustainability.

Measurement Tools

The tool used to measure burnout of the critical care nurse pausing after a patient death to honor a patient after the patient passes away is the MBI-HSS-MP is a human services survey for medical personnel (Mindgarden, 2020). The MBI-HSS-MP is recognized as a leading measure of burnout and is validated by extensive research that has been conducted in more than 35 years since its initial publication by authors Christina Maslach and Susan E. Jackson (Mindgarden, 2020). The MBI-HSS-MP survey consists of 22 items that use a seven-point Likert scale ranging from zero, “never,” to six, “every day” (Mudallal et al., 2017). Nine items measure emotional exhaustion, five more measure depersonalization, and eight others measured personal accomplishment (Mudallal et al., 2017). The responses are a sum, and high scores for emotional exhaustion and depersonalization indicate higher levels of burnout. In comparison, high ratings for personal accomplishment indicate lower levels of burnout (Mudallal et al., 2017).

All critical care nurses that committed to participation completed this inventory. One nurse was out on family medical leave and unable to complete the survey before the survey closing. After implementing the intervention following a patient death, all critical care nurses who participated in the sacred pause and who initially committed and took the baseline survey before implementation repeated this same survey in May 2021. Administration of the pre-and post-survey was administered by the nurse manager electronically. Please see a sample copy of the MBI-HSS-MP form (Appendix L) used to measure burnout (Mindgarden, 2020).

Data Analysis

Demographic data was collected using the critical care nurse characteristics form (Appendix J). Data was analyzed using Excel descriptive on the nominal and interval data and displayed in table form (See Appendix M). To determine if prevention of burnout occurred in the critical care nurse (Aim One), the interval data of the MBI-HSS-MP survey were analyzed using International Business Machines Statistical Package for the Social Sciences Statistics (Version 26) predictive analytics software. The analysis methods were frequency distribution of the MBI-HSS-MP means overall and the dimensions of the three subscales: emotional exhaustion, depersonalization, and personal accomplishment before and after the intervention. To determine the use and progressive implementation of the sacred pause naturally following patient death (Aim Two) frequency distribution was conducted on the nominal data.

RESULTS

Implementation

The project took place during a global pandemic. The facility was going through many changes structurally and culturally during these unprecedented times. The staff participating in this project faced challenges outside of the work setting they most likely had not faced before. Many of the staff had faced death/personal loss of family and or friends and were unable to participate in meaningful personal rituals following the loss of their loved ones. The need for the implementation of this project was even more critical during these unforeseen times. The nurses not only faced these challenges at home but also at work. The context supported and increased the purpose of the project to prevent burnout and thereby promote resilience.

While completing this project, a few challenges arose with a need for a revised plan. In the pre-intervention phase, staff education and introduction of the change initiative took place.

Staff verbalized understanding and completed return demonstration of the intervention during these educational sessions. Staff also completed the pre-test, one staff member did not complete the pre-survey by the deadline due to approved medical leave, and the revised plan included closing the pre-survey as all other staff had completed the survey. During the project's intervention phase, fewer patient deaths occurred than the prior six months before the project began. The revised action plan for this was more frequent reminders and education in the staff safety huddles. There was a twice per week reminder of this project plan by the charge nurse during the week and again on the weekends. There were no adjustments made during the post-intervention phase of the project, and compilation of data and a final report occurred.

Outcomes

Thirty-one critical care nurses completed the demographic questionnaire. In terms of credentials, 8 of the 31 participants were LVNs (26%), and 23 were RNs (74%). In terms of years of experience, less than one year experience, 19% (n=6), one year to five years' experience 48% (n=15), five-plus to ten years 10% (n=3), ten plus to twenty years 13% (n=4), and twenty-plus years 10% (n=3). Ninety percent (n=28) of the participants reported they had participated in a medical alert/code. The remaining 10% (n=3) reported never participating in a medical alert/code. Also, 68% of the nurses reported experiencing the death of a patient (n=21), and 32% reported not experiencing the death of a patient (n=10). Please see Appendix M demographics.

Regarding Aim 1, the pre-and post-intervention mean for emotional exhaustion was pre-score ($m=2.27$, $n=31$), post-score ($m=2.41$, $n=28$). The mean for depersonalization was pre-score ($m=0.88$, $n=31$), post-score ($m=0.94$, $n=28$). Personal accomplishment had a mean pre-score ($m=.9$, $n=31$), post-score ($m=4.85$, $n=28$).

Regarding Aim 2, during the 12-week project implementation, two patients died in the critical care unit. Each patient length of stay was reported as 62 days and 19 days, respectively, and both patients were on comfort care at the time of death. No family or visitors were present at the time of death for one of the patients. There were a total of two patient deaths on this unit. The completion of the sacred pause occurred after both deaths. In addition, there was a death in the other unit of the hospital. A sacred pause was completed following this death also even though this was not the project site. When the first death occurred, there were a total of four out of eight RNs that completed the sacred pause. When the second death occurred, a total of five out of eight RNs completed the sacred pause.

DISCUSSION

The purpose of this evidence-based change initiative was to prevent critical care nurse burnout and thereby promote resilience in a Central Texas hospital by instituting an intentional sacred pause following a patient death. The secondary goal of the project included the progressive implementation of the sacred pause on the project unit. While improvement was lacking by at least 10% in one of the dimensions of the three subscales, emotional exhaustion, depersonalization, and personal accomplishment, the scores showed prevention of burnout overall and minimal burnout. All post-intervention average scores met the goal of less than three for emotional exhaustion ($m=2.41$, $n=28$), less than three for depersonalization ($m=0.94$, $n=28$), and greater than three for personal accomplishment ($m=4.85$, $n=28$), indicating prevention of burnout and thereby promotion of resiliency in the critical care nurse. The second aim was also met due to staff completing the sacred pause intervention following both patient deaths at 100%, along with 50% or more of the critical care nurses participating in the sacred pause event. The

first death was 50% participation; the second death was 63% participation of the critical care nurses assigned and working on the unit at the time of death.

Through this project, there were successful moments and also a few challenges. One major success was implementing a sacred pause following a patient death on the other unit of the hospital. The charge nurses on both units for the shift were included in our critical care unit's initial training and project plan. Because of our culture and environment, it is not uncommon for our nurses to work in the other unit within our hospital. This was the primary nurse's (new nurse of three months) first experience of a patient death and the primary nurse felt supported with this intervention. Another nurse reported that she had been a nurse for a long time and had never participated in an intervention like this before, but it was refreshing to honor the patient and caregivers with the team's support. All of the team members were there to support one another. One nurse said she was thankful for the support of the charge nurses in a time like this. After other sacred pause events, staff reported it being a nice way to pay their respects to the patient, patient family, and team of caregivers. Challenges also arose with a need for a revised plan. Fewer patient deaths occurred then compared to the prior six months before the project began. The revised action plan for this was more frequent reminders and education in the staff safety huddles.

Hospital leadership and LTAC staff continued to voice their desire to support this evidence-based change initiative ongoing and promote nurse health through daily initiatives. The goal of the next cycle of this project will be to implement this initiative on the other unit of the hospital as many staff expressed the desire to continue to do this practice. With this hospital being a part of a large healthcare system, a future cycle of this project will be to implement this change initiative out on other units of other hospitals. Care delivery changed within this unit by

promoting a healing work environment and has fostered the ability to be successful in bringing about and sustaining this practice change initiative. There have been more deaths since the end of this project timeline, and the critical care nurses continue to practice this change initiative on their own.

The sacred pause can be considered self-care for critical care nurses and can also demonstrate organizational support when there are policies in place to introduce new hires to the practice. Many end-of-life situations are fraught with ethical implications. Many critical care nurses voiced that the ritual of a sacred pause makes their efforts feel appreciated. The death of a patient is a stressful situation to handle, even for the most seasoned nurses. The critical care nurses on the critical care unit of this practice change project voiced that they complete specific tasks soon after the patient death to include post-mortem care, calling families, life donations, updating providers, documentation, and the responsibility of taking care of other patients. They can lead to physical and psychological repercussions for the nurse (McAdam & Erikson, 2020). Also, the hectic pace of the critical care unit environment and workload expectations leave minimal time for the nurse to emotionally process the death of their patients, and their feelings may go unprocessed.

Additionally, nurses may have little to no formal training in coping with their feelings and grief (McAdam & Erikson, 2020). Many nurses feel that the ritual of a sacred pause makes their efforts feel appreciated (Kapoor et al., 2018). The critical care nurses on the critical care unit of this practice change project voiced this same appreciation. A study discussed organizational benefits from providing training and support for personalized rituals among team members, especially the new staff at greater risk for burnout (Montross-Thomas et al., 2016). Opportunities such as initiatives supporting patients, families, and support staff will comfort

nurses and families. A study revealed that apart from playing the critical role of being a patient advocate, the critical care nurse felt ethically responsible for doing his or her best (Naidoo, 2014). Additional recourses supporting a personally meaningful ritual such as the sacred pause include bereavement services, support groups, chaplains, and licensed professional counselors. Other supportive measures for overcoming the threats on a critical care unit include a lack of community placement resources.

Limitations

Observed changes such as involuntary and voluntary turnover may have an impact on the sustainability of this project. With the loss of the long-standing staff on the unit, agency nurses were hired. Ongoing education, reminders, and follow-up at the monthly charge nurse meeting will minimize the barrier of staff turnover and education around the intervention. During the time of the project, the global pandemic is another essential factor to consider when reviewing the survey results. Also, a historical ice storm took place, and staff and the leaders stayed in the hospital for over a week. Other important factors to mention include the death and loss of staff members' family/loved ones during this time. Many staff were unable to have essential rituals such as visitation or funerals due to the pandemic, which led to voiced emotional exhaustion by the critical care nurses.

Interpretation

Education to implement this process change and improved communication of all critical care nurses involved and were guided by the overarching framework PDSA, and was more specifically guided by Kurt Lewin's Change Theory (Shirey, 2013). Lewin's Change Theory helped guide the evidence-based change project because it identified the need to change practice patterns (Shirey, 2013). During the implementation of change, education was provided on the

intentional sacred pause and sacred pauses were implemented after every patient death (change stage). Final steps included an assessment of the change to determine the level of success. The results were desirable, but secondary to the short duration and limitations, a second PDSA cycle is necessary before determining success (refreezing stage). The final stage is where the intervention becomes embedded into the culture of the unit. This stage is critical due to institutionalizing the change and will be crucial to its sustainability over time.

The project took place during a global pandemic. The facility was going through many changes structurally and culturally during these unprecedented times. The staff participating in this project faced challenges outside of the work setting they most likely did not face prior. Many of the staff had faced death/personal loss of family and friends and could not participate in meaningful personal rituals for their loved ones following the loss.

It was evident that the charge nurses were open to the idea of a sacred pause and adopting the intervention. The charge nurses are the gatekeepers/change agents that helped ‘spread the word.’ More and more people became open to it, as evidenced by the sacred pause intervention on a different unit during the project implementation phase. Financial implications of sustainability have proven to be low-cost related to the sustainability measures needed throughout the project.

There was one death on the skilled nursing unit during the project implementation phase. The skilled nursing unit was not the project site; however, the sacred pause occurred naturally. Two critical care nurses, both trained for the intervention where the project was conducted, participated and led the sacred pause. Additional participants included a respiratory therapist, chaplain, and medical-surgical nurse as part of the natural implementation of the sacred pause, even though it was not on the critical care unit. This project was the first PDSA cycle as a part of

the plan; accomplishments and the need for modifications were recorded and is important along with taking steps towards sustainability and plans for improvement to restart the PDSA cycle again (IHI, 2020). The plan is to continue to bring about the change, financial implications include minimal impact to sustain this evidence-based change initiative in other areas.

Conclusion and Implications

While the MBI-HSS-MP inventory scores were similar in both pre-and post-intervention, the results demonstrated minimal nurse burnout, and this evidence-based practice change initiative was well received by the staff members in the hospital and is an initiative supportive of health promotion on this unit. There were positive changes to the clinical setting resulting from the intervention, which can be considered clinically significant. Participation in the intervention was documented, and the use and natural implementation of the sacred pause following patient death was utilized. According to Havens et al. (2018), care for patients requires the care of the critical care nurse as part of the quadruple aim. The fourth aim is focused on improving the critical care nurses experience of providing care. Authentic, complex, and resilient leadership is crucial amongst nurses in the ever-changing evolution of healthcare to achieve the quadruple aim of improving the care experience, improving population health, reducing the cost of care, and improving the critical care nurses' experience (Jeffs, 2018). A healthy nurse is one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal, and professional well-being (Moore, 2016). Often the most critical patient, a nurse cares for, is oneself (Moore, 2016).

It is evident by the complex work environment and other stressful external factors throughout this project that the continuation of this intervention with further exploration around other health-promoting activities and with other provider groups be explored. Critical care nurses

are a vulnerable population susceptible to burnout. Being proactive around the health promotion of the critical care nurse will prevent the risk for burnout. Burnout impacts critical care nurses across the globe; if critical care nurses and healthcare organizations are diligent in implementing the sacred pause intervention discussed in this essay, they will see positive patient outcomes, quality care provided, and it will ultimately serve the greater community (Shanafelt et al., 2018). Healthcare organizations must invest in fostering an environment that provides nurses, critical care nurses, with the support they need to care for themselves.

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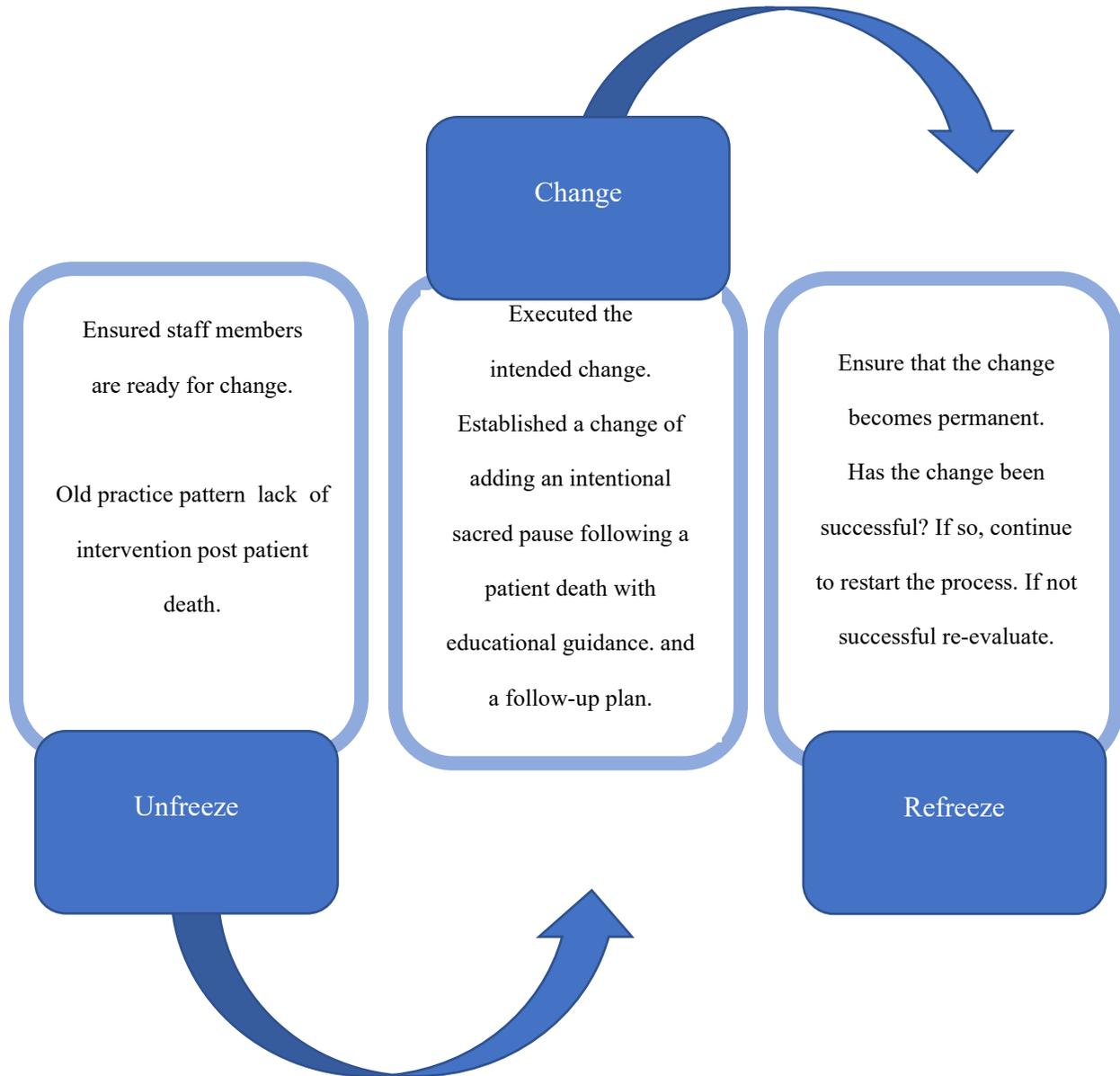
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APPENDIX A: Plan-Do-Study-Act



APPENDIX B: Kurt Lewin's Change Theory



APPENDIX C: Risk Assessment

Risk	Impact	Countermeasure	Resources	Barriers
1. Small sample size of staff participation from intervention to follow-up MBI documentation	-Lack of data to see if the project had a positive or negative impact	-Education to the staff at the start of the three-month project timeline	-Education to the charge nurses, front-line leaders/gatekeepers	-Competing priorities -Desire to participate
2. Uncontrolled number of deaths	-Zero deaths during the timeframe would be a showstopper for this project	-Open line of communication with medical director and hospital leadership to raise awareness of the project	-Open line of communication with the physicians, leadership, and bedside staff members to raise awareness	-Low acuity patients

<p>3. Capture all deaths that occur so that none are missed</p>	<p>-Missed opportunity if not captured</p>	<p>-Locate a report in the documentation system to capture all deaths</p>	<p>-Education to the charge nurse to document deaths and staff member participation following a death</p>	<p>-Unable to locate the report in the documentation system or rely on the unit clerk to complete process request</p>
<p>4. COVID-19 pandemic</p>	<p>-Sick staff members during implementation phase; follow-up phase missed opportunity</p>	<p>-Utilize available staff</p>	<p>-Open line of communication throughout the project with the team</p>	<p>-Staff members out on leave or sick</p>
<p>5. Staff completing the MBI-HSS-MP inventory with honest</p>	<p>-Data skewed</p>	<p>-Assign staff members a number with the initial survey; staff will need to</p>	<p>-Open line of communication; ensure confidentiality</p>	<p>-Staff trust in a confidential process</p>

answers due to fear of exposing results		remember the number if a death occurs and they participate in a sacred pause session		
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APPENDIX D: Texas A&M University-Corpus Christi Institutional Review Board and Approval

Dear Heather DeGrande,

Activities meeting the DHHS definition of research or the FDA definition of clinical investigation and involves human subjects are subject to IRB review and approval.

On 12-15-2020, the Office of Research Compliance reviewed the project below and determined that the proposed activity does not meet the FDA definition of a clinical investigation or DHHS definition of research:

Type of Review:	Not Human Subjects Determination
IRB ID:	TAMU-CC-IRB-2020-12-127
Project Lead:	Heather DeGrande
Title:	Implementation of a Sacred Pause Following a Patient Death on a Long-Term Acute Care Unit to Decrease Critical Care Nurse Burnout
Rationale:	The project will not develop or contribute generalizable knowledge

Therefore, this project does not require IRB review. You may proceed with this project.

Limits to this determination:

1. This determination applies only to the activities described in the documents reviewed. Any planned changes require submission to the IRB to ensure that the research continues to meet criteria for a non-human subject research determination.
2. This project may NOT be referenced as "IRB approved".

The following statement can be included in the manuscript: "This Project was reviewed and determined to not meet the criteria for human subjects research by the Texas A&M University-Corpus Christi Institutional Review Board."

Please do not hesitate to contact the Office of Research Compliance with any questions.

Respectfully,

Germaine Hughes-Waters

Office of Research Compliance

APPENDIX E: Project Site/Hospital Setting Institutional Review Board and Approval

QUALITY IMPROVEMENT VS. RESEARCH ACTIVITY DETERMINATION FORM		
Date:	1/14/21	
Project Leader:	Nicole Voltek-McN, RN, HACIP	
Department/Division:	Baylor Scott + White Health Continuing Care Hospital/LTAC	
Project Title:	Implementation of a Sacred Pause Following a Patient Death on a Long Term Acute Care Unit to Decrease Critical Care Nurse Burnout	
Instructions: Answer YES or NO to each of the following statements about QI projects.	YES	NO
The aim(s) of the project is to improve the process or delivery of care with established /accepted quality standards, or to implement change according to mandates of the hospital's Clinical Quality Improvement programs. There is no intention of using the data for research purposes.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The specific aim is to improve performance on a specific service or program in the hospital and is part of usual care. All participants will receive standard of care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The project is NOT designed to answer a research question or test a hypothesis and is NOT intended to develop or contribute to generalizable knowledge.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The project does NOT follow a research design (e.g., hypothesis testing or group comparison (randomization, blinding, control groups, prospective comparison groups, cross-sectional, case-control)). The project does NOT follow a protocol that over-rides clinical decision-making.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience (i.e. off label uses of FDA approved drugs/devices).	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The project is conducted by staff where the project will take place, and involves staff who are working at, or patients who are seen at the institution.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The project has NO funding from federal agencies or research-focused organizations, and is not receiving funding for implementation research (see External Funding on pg 1).	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The clinical practice unit (hospital, clinic, division, or care group) agrees that this is a QI project that will be implemented to improve the process or delivery of care (i.e., NOT a personal research project that is dependent upon the voluntary participation of your colleagues, students and/or patients).	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If there is an intent to, or possibility of publishing your work, you and your Department/QI Oversight group are comfortable with the following statement in your methods section: "This project was undertaken as a quality improvement initiative at X hospital or clinic [fill in appropriate entity name], and as such was not formally supervised by the Institutional Review Board, per their policies on quality improvement initiatives."**	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ANSWER KEY: If the answer to ALL of these questions is YES, the activity may be considered a Clinical Quality Improvement/Measurement activity that does not meet the definition of research. IRB review may not be required. Email a completed copy of this form along with an abstract or summary of the proposed activity to the IRB Office (IRBOFFICE@BSWHealth.org) and keep a dated copy of this checklist in your files. If the answer to ANY of these questions is NO, the project must be submitted to the IRB for review.		

APPENDIX F: Baylor Scott and White Health-Health Insurance Portability and Accountability Act Confidentiality Agreement



Information for Students regarding Patient Privacy Rights (HIPAA)

The purpose of this communication is to emphasize to all students the commitment of Baylor Scott & White Health (BSWH) to protect the privacy rights of all our patients and the necessity of securing patient information in any form (electronic, paper, verbal, photography or filming). The consequences for a student failing to follow BSWH's policies and procedures protecting patient information or any misuse of patient information are severe.

As a student of BSWH, we may *only* access the patient information necessary for your role as a student. Students may *never* access any patient information for personal reasons (your own, family, friends, etc). ***If you don't need it to meet the objective of your student role, you are forbidden to access patient information.*** If you come across a family member or friend's information, do not access the information. If you need the information for your role as a student, bring it to the attention of your faculty or BSWH nursing staff. You cannot discuss it with your family, friends or staff. If a family member gives you permission to access their information or you need to review or obtain a copy of your own information, you are required to follow BSWH protocol and access that information through Release of Information. (ROI).

BSWH can and does monitor access to patient information. The identity of those accessing patient information is audited to ensure compliance with policies and procedures. If the audit or investigation reveals misuse of patient information, **disciplinary action, will be enforced. Violations of privacy rights will also be reported to the patient and the Office of Civil Rights (OCR). The OCR can find individuals civilly and criminally liable, including jail time, for violations of patients' privacy rights.**

Please carefully evaluate your use of confidential patient information. It is our sincere desire that no one lose his or her student role due to a violation of BSWH policies and procedures concerning the protection of the privacy and confidentiality of patient information.

If you have questions or concerns regarding access of patient information, or you are not sure what you are allowed to do within your student role, ask your clinical instructor and/or unit supervisor, manager. You may also contact the Corporate Compliance Department at 254-215-9022 the Privacy Hotline 254-724-7600 or e-mail inquiries to HIPAA on Outlook. Additional information and FAQ's are available on the HIPAA website on Scott & White Intranet.

I acknowledge I have read and understand BSWH's policies and procedures for protecting the privacy and confidentiality of patient information.

By signing this Acknowledgement, I acknowledge, understand and agree that my failure to abide by the rules, guidelines, policies or procedures that BSWH currently has in place or that may hereafter be developed, may result in disciplinary action up to and including termination of my student role at BSWH. I also understand that I may also be held civilly or criminally liable for my actions.

Failure to acknowledge does not negate my responsibility to follow BSWH policies and procedures.

 Nicole White
Signature

 7/27/20
Date

- Yes, I acknowledge I have read and understand Baylor Scott & White's policies and procedures for protecting the privacy and confidentiality of patient information.
- I have additional questions and will contact the Scott & White Privacy Office at 254-724-7600. (This lesson will not be completed at this time.)

APPENDIX G: Letter of Support



Continuing Care Hospital
546 North Kegley
Temple, Texas 76502
254.215.0900
www.BaylorHealth.com

10/2/2020

Dr. Sara Baldwin
Associate Dean for Academic Programs
College of Nursing and Health Sciences
Texas A&M University – Corpus Christi
6300 Ocean Drive
Corpus Christi, TX 78412

Dear Dr. Baldwin,

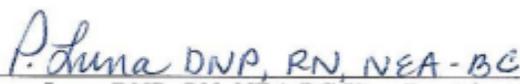
The purpose of this letter is to provide Nicole Volek, a Doctor of Nursing Practice student at Texas A&M University College of Nursing and Health Sciences, support in conducting a quality improvement project at Baylor Scott and White Health Continuing Care Hospital. The project, "Care of the Caregiver: Implementation of a Sacred Pause Following a Patient Death on a Long-Term Acute Care Unit to Decrease Burnout", entails lowering feelings of stress and burnout following a patient death, by providing educational sessions related to a personal resilience technique "sacred pause" to critical care nursing staff at the Continuing Care Hospital.

The purpose of this project is to lower feelings of stress and burnout. The Continuing Care Hospital was selected for this project because of the patient population of higher acuity patients and longer length of stay. Nicole Volek is employed at this institution, and has an interest in improving care at this facility.

I, Peggy Luna DNP, RN, NEA-BC, Vice President of Patient Care Services-Critical Care Services at Baylor Scott and White Health Temple Region including the Continuing Care Hospital, do hereby fully support Nicole Volek in the conduct of this quality improvement project, "Care of the Caregiver: Implementation of a Sacred Pause Following a Patient Death on a Long-Term Acute Care Unit to Decrease Burnout" at the Baylor Scott and White Health Continuing Care Hospital.

I also approve Nicole Volek to access protected health information (PHI) for purposes of conducting this quality improvement project. She has signed a HIPAA release form.

Sincerely,



Peggy Luna DNP, RN, NEA-BC Vice President Patient Care Services-Critical Care Services

Sacred Pause

The purpose of the **Sacred Pause** is to honor a patient and the caregiver team.

It is a 15-30 second period of silence shared by the caregivers after a patient's death. A patient death, expected (comfort care), or unexpected (medical alert/code blue).

The **Sacred Pause** provides closure to the relationship between the caregivers and the patient, preparing the caregiver team to care for other patients.



Begin by asking the team if it would be okay to take a moment and honor the patient.

If the care team has questions or concerns, please guide them to the project director/nurse manager.

It is 100% okay if someone prefers to opt-out of the experience and leave the area.

The Sacred Pause is a practice that allows one to honor in silence and in a way that gives meaning.

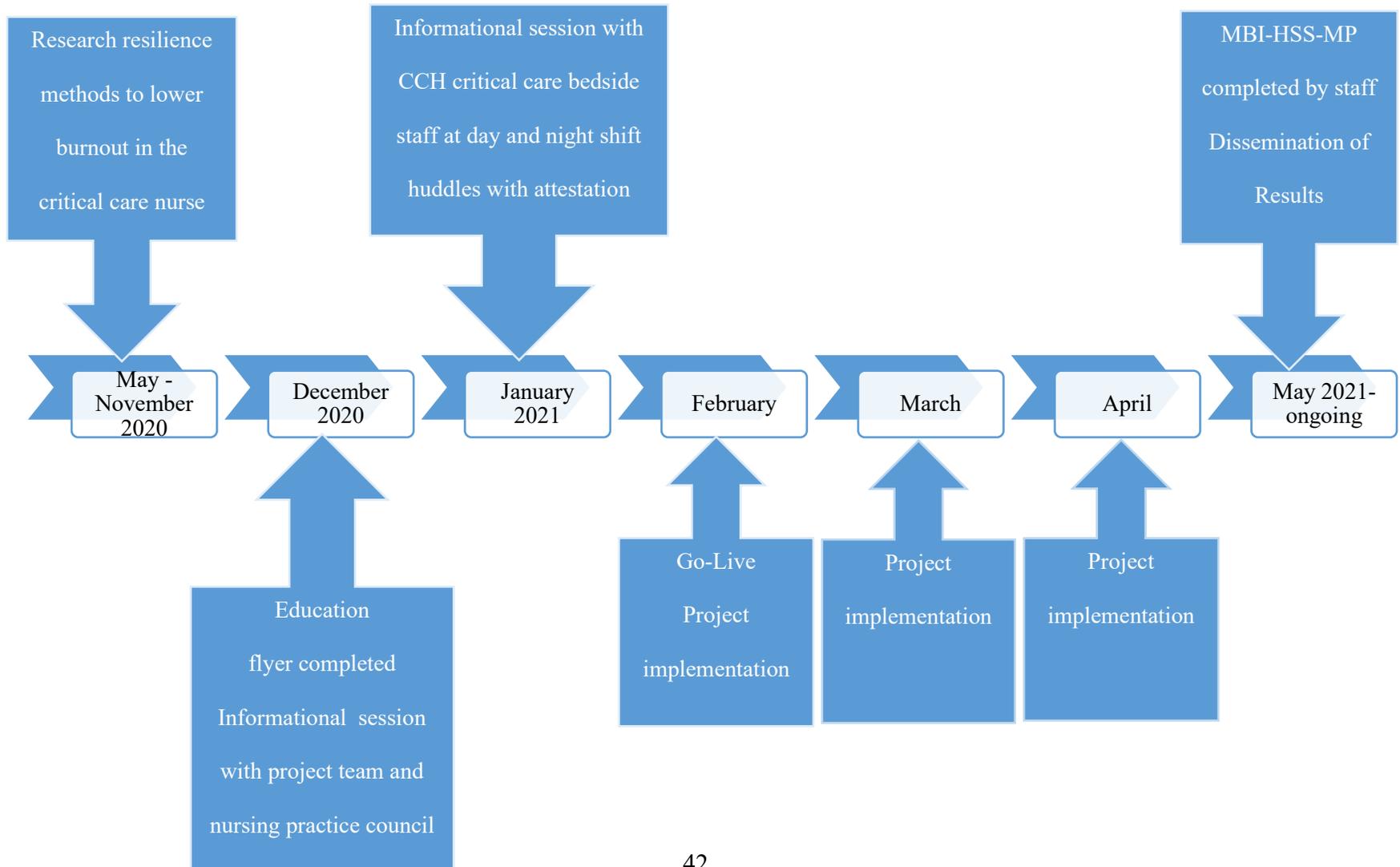
Participation is voluntary.

The Sacred Pause is usually performed at the bedside but may be performed in another location depending on the situation or caregiver team.

Anyone can lead the Sacred Pause and any caregiver can participate.

The Sacred Pause after an expected (comfort care) death may be a different dynamic than after an unexpected (medical alert/code blue) death.

APPENDIX I: Timeline for Project Implementation



APPENDIX J: Critical Care Nurse Characteristics Form

- 1) Date: _____
- 2) Credentials: _____
- 3) Estimated-Days/Months/Years of Experience as a critical care nurse: _____
- 4) Have you participated in a Medical Alert/Code Blue as a critical care nurse? Y N
- 5) As a critical care nurse have you experienced the death of a patient? Y N

CONFIDENTIAL

Please return completed form page 1 of 1 to nurse manager.

NOT TO BE ENTERED INTO PATIENT MEDICAL RECORD

APPENDIX K: Post Death Evaluation Form

Patient, Unit, Staff and Event Information:

Unit Name: LTAC Unit Specific Location of Event (e.g., RM Number): _____

Date of Event: _____ Time of Event: _____ Sacred Pause with Staff Completed Y N

Patient Date of Admission: _____

Medical Alert/Code Blue Y N

Comfort Care Y N

Family/Visitor Present Y N

Credentials of Staff Member Participation in Sacred Pause:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

CONFIDENTIAL

Please return completed form page 1 of 1 to nurse manager.

NOT TO BE ENTERED INTO PATIENT MEDICAL RECORD

APPENDIX L: Maslach Burnout Inventory Health Services Survey for Medical Personnel

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**Citation of the instrument must include the applicable copyright statement listed below.
Sample Items:**

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I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some recipients.

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MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):

I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some patients.

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MBI - Educators Survey - MBI-ES:

I feel emotionally drained from my work.
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APPENDIX L: Continued

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MBI - General Survey - MBI-GS:

I feel emotionally drained from my work.
In my opinion, I am good at my job.
I doubt the significance of my work.

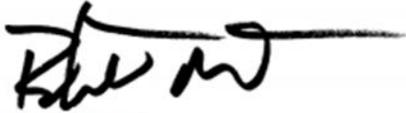
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MBI - General Survey for Students - MBI-GS (S):

I feel emotionally drained by my studies.
In my opinion, I am a good student.
I doubt the significance of my studies.

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Sincerely,

A handwritten signature in black ink, appearing to read 'Robert Most', with a long horizontal line extending to the right.

Robert Most
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APPENDIX L: Continued

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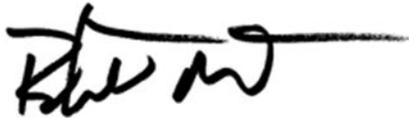
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Sincerely,

A handwritten signature in black ink, appearing to read 'Robert Most', with a long horizontal line extending to the right.

Robert Most
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APPENDIX M: Demographics

Characteristic	Frequency	Percent
Credential		
RN	23	74
LVN	8	26
Years of Critical Care Nurse Experience		
Less than 1 year	6	19
Range 1-5 year	15	48
Range 5 plus-10 year	3	10
Range 10 plus-20 year	4	13
20 plus years	3	10
Prior to Project Implementation-Participation in Medical Alert/Code		
Yes	28	90
No	3	10
Prior to Project Implementation-Experienced the Death of a Patient		
Yes	21	68
No	10	32