

**To what extent does in-person training, specifically new employee orientation,
impact burnout among professional dementia caregivers?**

Final Research Report
IMT 570 Analytic Methods for Information Professionals
iResearchers
Amir Ali, Naga Soundari Balamurugan, Tiffany Ku, Kevin McCraney
Group Contact: tk11@uw.edu

EXECUTIVE SUMMARY

We explored the question “to what extent does in-person training, specifically new employee orientation, impact burnout among professional dementia caregivers?” through a case study. At work, burnout has been associated with deficient patient care and job satisfaction (Surr et al., 2017). We surveyed professional caregivers at one facility in the Greater Seattle Area to gauge how orientation training prepares staff members to provide care and manage personal stress.

We created a survey, using the Maslach Burnout Inventory (MBI) to score the degree of burnout experienced by the caregivers. We also had respondents reflect on their experiences and provide suggestions to improve training. As a baseline, we compared the results of our study to Poghosyan et al. (2009). We used family caregiver transcripts to supplement our qualitative analysis. Overall, we found moderate levels of burnout among our population, and discovered caregivers felt orientation training did not adequately prepare them to care for dementia patients or handle stress.

This is problematic. Employees are not receiving support they need. To address the problem, we suggest the following: caregiver mentorship, management dialogue, employee-led discussion groups, review of training curricula, and experimental workshops. If resources are an issue, we believe implementing a mentorship program takes priority.

I.) INTRODUCTION

Dementia is a term that describes a group of symptoms associated with deteriorating brain functions such as memory, thinking, behavior, and the ability to perform day-to-day tasks. It is important to understand that each instance of dementia is unique and the causes are not always consistent. According to the World Health Organization, around 47 million people are affected by dementia with 10 million new cases surfacing each year (WHO, 2017). Dementia is one of the primary causes of disability and dependency among elderly populations (WHO, 2017).

Though patients with dementia suffer immensely, families and caretakers also grapple with the severe physical, psychological, social, and financial burdens of the syndrome. According to the National Alliance of Caregiving, 39.4 million Americans work as caregivers (Douangradtdy, 2017). Of the 39.4 million, 40% have reported feeling a high level of burden from their job duties (Douangradtdy, 2017). As a result, caregivers might experience burnout, a state of complete physical, emotional, and mental breakdown. Burnout is often job-related and accompanied by feelings such as guilt, fatigue, chronic stress, anxiety, and depression. Burnout may occur when caregivers are not receiving proper support and assistance. The unintended consequences of burnout can truly threaten quality of life for both the patient and caregiver.

Based on this, we were initially interested in studying how to mitigate caregiver burnout. When we conducted a basic literature review, we found studies either focused on burnout among professional healthcare providers or effectiveness of training in medical settings. However, we weren't finding any studies that brought the two different aspects together. We further identified a unique opportunity for our research problem due to a personal contact. We have a personal contact who is Director of Nursing at a skilled nursing and rehab facility for elderly patients in the Greater Seattle Area. Having this contact gave us a special level of exposure and access for an exploratory case study. After preliminary conversations with our contact, they shared that the facility's new employee orientation training program included a section on dementia, which seemed to be the most effective training method for educating caregivers. We felt that training specific to managing patients with dementia and handling job-related stress might address some of the effects of caregiver burnout. We formed the basis for our research study from there, which aims to answer the following question: **to what extent does in-person training, specifically employee orientation training, impact burnout among professional dementia caregivers?**

SIGNIFICANCE OF RESEARCH

Finding a way to manage and address caregiver burnout is crucial, but determining which interventions are beneficial can be complicated and unclear. In terms of burnout, research by Truzzi et al. (2012) concluded that caregiver depression is highly associated with emotional exhaustion. Van der Lee et al. (2014) performed a meta-analysis of studies on caregiver stress and found that the only clear determining factor in the reduction of stress was positive self-esteem, and that influence of social support on reducing burnout was unclear. Additionally, Gilhooly et al. (2016) reviewed stress and coping behaviors across literature from 1988-2014 and found that social-emotional support was a major factor in the reduction of stress. The varying outcomes of these two studies asserts the relevance of our study. If we can construct a clearer picture of the possible interventions that could mitigate burnout, we can enable workers to be more effective at their on-the-job duties.

Further, the Surr et al. (2017) review found that certain features of dementia training that may be associated with better quality of care and clinical effectiveness such as relevance of the training, practical tools or strategies, including experiences of those living with dementia through video stories, group learning, in-service resources, duration of training, and scheduling. Trainings oriented specifically around dementia can provide useful context, tools, and outlets for caregivers to manage individual stress and provide the best patient care. We also consulted a study by Poghosyan et al. (2009), which was an investigation of nurse burnout across 8 different countries using the Maslach Burnout Inventory. These studies guided our research and provided a baseline by which to benchmark the data we collected.

BOUNDARIES

As mentioned above, this opportunity for research arises from personal connection. The scope is limited because we are only examining burnout and training among professional caregivers at one nursing facility, rather than at a larger scale. The particular facility serves around 90 patients and is a for-profit, individually-owned institution. According to the Director, about 60% of patients at the facility have some form of dementia. The facility employs approximately 30 registered nurses (RNs) and 50 certified nursing assistants (CNAs). We had about six weeks to complete the project, thus we had significant time constraints for collecting and analyzing data. Treating our project as a cursory pilot study could provide a foundation or suggest a need for further larger-scale studies on the subject of dementia caregiver training. However, the bounds of our study are confined to the single facility we selected.

II.) METHODS

SAMPLING & SELECTION OF SUBJECTS

As previously mentioned, we have a personal contact who is a domain expert, working as Director of Nursing. With their consent, we focused our research study at their facility. Our personal contact acts as a gatekeeper to other experts in the field. The sampling criteria that we used to determine our target population was the snowball method. Snowball sampling involves, “making initial contact with key informants who, in turn, point to information-rich cases” (Pickard, 2015, pg. 65). Our rationale for selecting participants is based on the assumption that professional caregivers (as well as administrators that manage caregivers) are domain experts because they encounter and care for patients with dementia daily. They are best suited to evaluate both quality of patient care provided and degree of burnout.

DATA COLLECTION METHOD

We used a survey as our primary instrument of data collection. Our domain expert distributed the survey as a web link format to the RNs and CNAs on our behalf. The survey was designed to collect both quantitative and qualitative data. This mixed-methods strategy provided us with more flexibility. We created the survey using SurveyMonkey.com. SurveyMonkey is a user friendly online survey-creation platform, which we chose because it is easy to use and low-cost. In addition, SurveyMonkey provides many useful charts and data summaries, allowing users to export results in varying formats.

The survey questions on burnout were adapted directly from an abbreviated version of the Maslach Burnout Inventory (hereafter referred to as “MBI”). The MBI is a well-respected instrument in academia used to evaluate and identify burnout. We elected to use an abbreviated version from the MBI Manual (Maslach, 1996) because it is more concise and easier to administer. We anticipated that shortening the survey would reduce time to complete, which would ostensibly increase engagement and response rate. Please refer to Appendix A for the complete set of survey questions, including the abbreviated MBI.

Our questions on caregiver training received were formed with guidance from Gilhooley et al. (2016) and Van der Lee et al. (2014). Though there are aspects where their results are contradictory, both of these meta-analyses suggest that primary issues in the long-term efficacy of training programs for dementia caregivers are based on aspects of the caregiver’s internal locus of control and social support. We targeted these two themes to examine aspects of our population’s experience with effectiveness of their orientation training as it relates to patient care and self-care.

There is an optional qualitative open-ended question at the end of the survey to see if caregivers had any suggestions for improvement in the training received. We also asked survey participants to rate their job satisfaction. In addition, we collected basic demographic data in the form of gender and age. The responses to these questions were not required. We chose this line of questioning to see if any interesting correlations would emerge.

ETHICAL CONSIDERATIONS

The issues surrounding caregiving and dementia are extremely sensitive. Asking participants to evaluate their personal experiences could be triggering for them. Therefore, it was important to be completely transparent with our participants when explaining methods of data collection and overall purpose of our research. To address ethical concerns, we embedded a statement of consent in the web form at the beginning of our survey. We also provided our contact information to participants and made sure they had the option to opt out at any time. Please refer to Appendix B for our consent form.

Further, because our study concerns workplace behaviors, there was potential for power differential to emerge between our recommender and perceived survey candidates (for example, manager identifies his/her direct report). Since we used a snowball technique to identify study participants, the candidate might feel pressured to participate or decline to participate due to the work relationship. Though the survey was anonymous and the outcome should not impact their workplace experience in any way, we wanted to avoid increasing a participant’s stress level in a study about the management of stress.

A secondary aspect of consent was preserving anonymity on the part of the institution we worked with. Though we may have the trust of a confederate at the institution, we have elected to not identify any of the focal points of our case study. Keeping anonymous the business and employees that we surveyed, prevents loss or profit from the results of the study, removing a possible incentive on their part. For example: if we identified participants, and the outcome of the study asserted that the workers were stressed out and the training materials were not useful, the facility could possibly experience a loss of business or damaged reputation.

III.) RESULTS AND ANALYSIS

SCOPE, LIMITATIONS, AND CONSTRAINTS

We were able to conduct our study because of a previously established personal connection at the facility. While implementing a case study for one facility rather than a random sample of regional facilities allows us to narrow the scope of our study, it opens our results to convenience bias. We recognize that since our study uses a convenience sample, our target population may not be completely representative.

Using the snowball sampling method ended up constraining us to a smaller possible pool of participants. However, we saw more potential for positive impact stemming from our results. We hoped that our domain expert would be able to learn from this example, iterate, and make immediate changes in training methods that might improve the current experience of the caregivers.

We also chose to organize our research project as a case study because of time sensitivity--class is 10 weeks, but ostensibly we only had 6 weeks to work on the project. It's difficult to address burnout on a large scale when we don't have resources at our disposal.

QUANTITATIVE ANALYSIS

We used the Maslach Burnout Inventory (MBI) scoring system to quantify the responses we received from the professional caregivers on their burnout experience. We received a total of 15 responses to our survey. We compared our results with the scores from the Poghosyan et al. (2009) study on nurse burnout. As previously mentioned in the methods section, we used an abbreviated version of the MBI. See Appendix A for the abbreviated MBI, as embedded in our survey.

The MBI measures three components of burnout: Emotional Exhaustion (EE), Depersonalization (DP), and Reduced Personal Accomplishment (RPA). Please refer to Appendix C for the MBI scoring criteria. As a baseline, we compared our data with the Poghosyan et al. (2009), which also used the MBI. The study provided us with a substantial quantity of control data to compare our results with. First, we extracted our data from SurveyMonkey in a CSV format. Next, we imported the Poghosyan et al. (2009) nurse burnout results into Excel and renormalized their MBI scores in order to compare with our 0-18 scale. This is a valid method, as there are various MBI versions that use different scales, all of which can be normalized and compared as per the MBI standard manual.

Then we ran a two-means T-Test comparing the means of each component of the MBI. We calculated the standard deviation using formulas integrated in Excel. We chose a T-Test statistic because we were comparing continuous values and assume the means are normally distributed, as per the nursing study.

The MBI results comparison of our study and the Poghosyan et al. (2009) study on nurse burnout are shown in the table below:

MBI Scoring	Our study		Nursing Study	
	Average	Standard Deviation	Average	Standard Deviation
Emotional Exhaustion	10.00	1.80	13.48	2.53
Depersonalization	2.27	0.37	11.37	2.55
Reduced Personal Accomplishment	14.87	2.94	10.12	1.97

Figure 1, comparison of our results vs. Poghosyan et. al (2009)

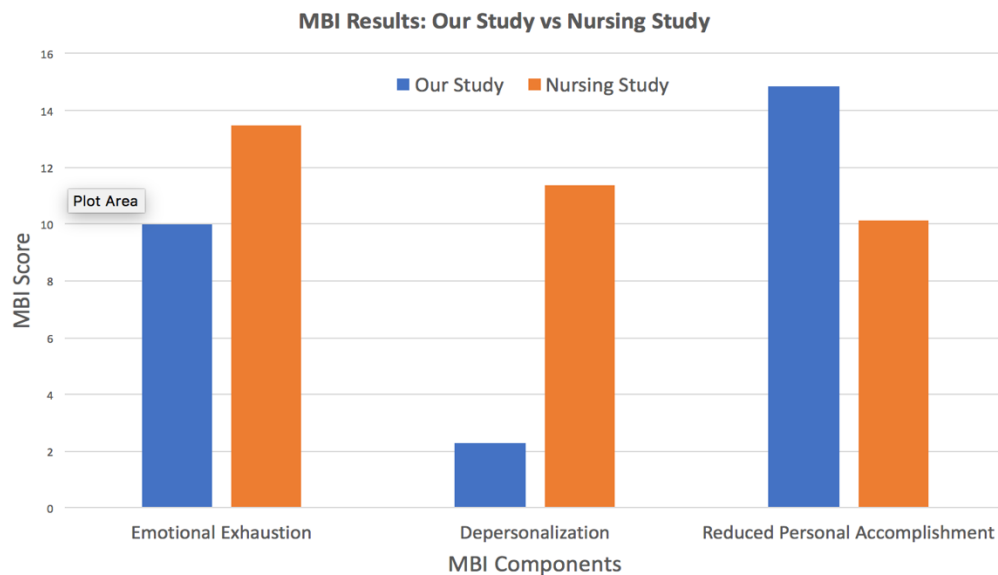


Figure 2, bar chart of our results vs. Poghosyan et. al (2009)

The chart above shows the comparison of our study with the nursing study on three MBI components. It is clear that the professional caregivers in our study undergo less burnout versus the

professional nurses from the Poghosyan et al. (2009) study. There is a significant difference in the scores for depersonalization scale, whereas the difference of the scores for other two components are not statistically significant. Even though the caregivers we surveyed experienced less burnout on average, their preparedness to provide care to patients with dementia was low. The responses to our survey question “As a result of your orientation training, to what extent did you feel prepared to provide care to patients with dementia?” indicated that only 20% of respondents felt well-prepared for dementia caregiving as a result of their orientation training. The graphical representation of patient care competency is shown below:

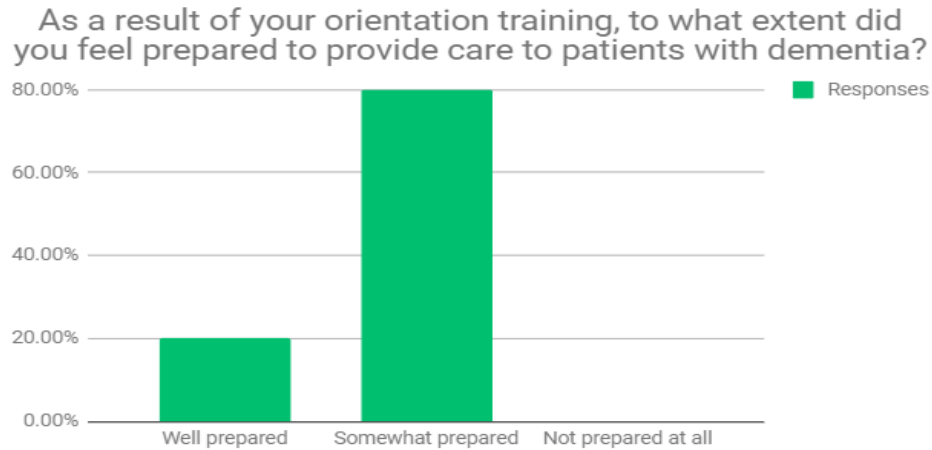


Figure 3, bar chart detailing degree of preparedness re: dementia care

The responses to our survey question, “As a result of your orientation training, to what extent did you feel prepared to manage job related stress?” indicated that only 15% of respondents felt well-prepared to handle personal stress as a result of their orientation training. The graphical representation of self-care competency is show below:

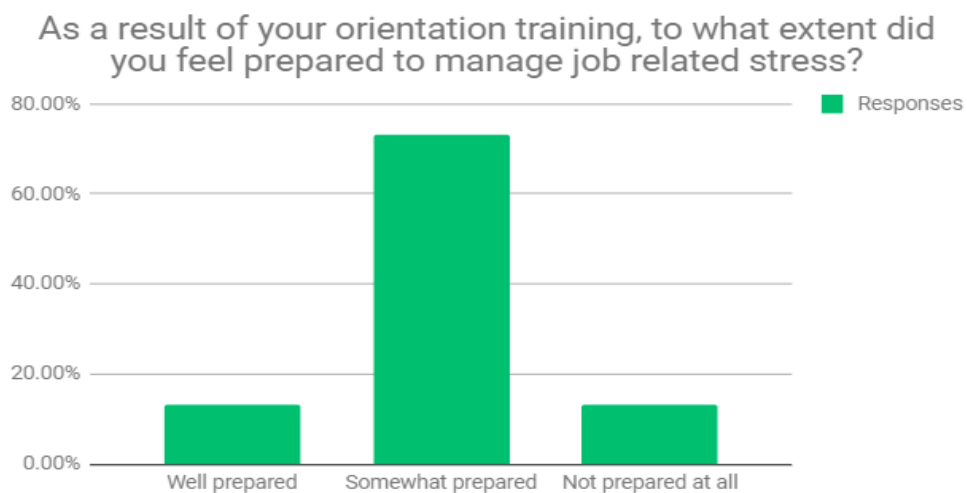


Figure 4, bar chart detailing degree of preparedness re: job stress

Overall, the MBI results illustrate that our respondents had a slightly lower degree of emotional exhaustion, as well as a lower degree of reduced personal accomplishment. Though the scores were lower in our respondents than in Poghosyan et al. (2009), an emotional exhaustion score of 10 still indicates a moderate level of burnout. Furthermore, the depersonalization score of our respondents was much lower as compared with nurses in the Poghosyan et al. (2009) study. We believe this may be due to the large age gap and difference in years of experience between the groups. The reported age of our population was within the 18-34 range, while most nurses surveyed in Poghosyan et al. (2009) had been practicing for 11 to 18 years.

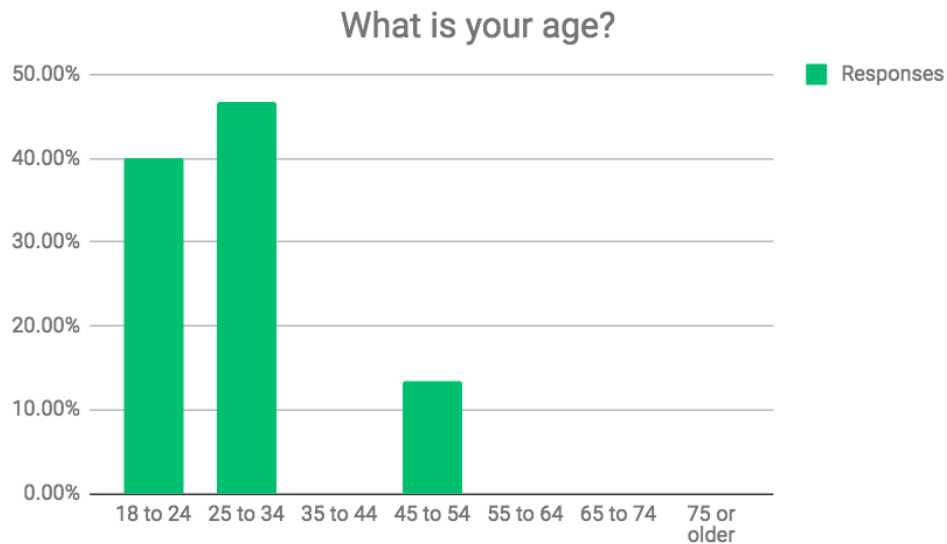


Figure 5, bar chart detailing participant age

Based on our quantitative data, our research contributes to the body of literature as it currently stands. Our population cited that they were dramatically unprepared through currently extant training procedures to provide care for dementia patients, and even less prepared to self-manage job-related stress. The MBI scores reported moderate burnout levels as well. With respect to the current orientation practices, this means that something is not working. Employees are not getting the information or support that they need, and further research is necessary in order to understand why (and under what circumstances) that is the case. Further, we believe that there is a lot of room for improvement in the orientation training at this facility.

QUALITATIVE ANALYSIS

Through our qualitative analysis, we were able to analyze the cursory responses to our own survey alongside the interview transcript data provided by the instructor, looking for large-scale commonalities and patterns in otherwise ambiguous data.

In our survey, we included an open-ended qualitative response question (see Appendix A). We analyzed the responses we received through our survey using the affinity diagram process (see Appendix C). After completing the exercise and identifying broad themes across our data, we decided to analyze the family caregiver transcripts provided from class as well, filtering by keywords to ensure relevance to our

study. Through this process, we were able to reduce the transcripts to about 25 entries, and then completed an affinity diagram. During the process of producing the affinity diagram, each team member had an opportunity to clarify their thoughts, provide feedback, and explain rationale for their particular descriptions when grouping findings.

Overall, we found many common themes between the professional caregivers and the family caregivers. Both groups had similar experiences and sentiment related to their job duties. They also expressed the need for and lack of training resources. We were able to combine the two sets of data to form one affinity diagram. Please refer to Appendix D for an image of our final affinity diagram.

Both the professional and family caregivers expressed opinions on the various delivery methods of caregiver training they thought would be most effective for treating patients with dementia. Some of the respondents indicated that learning from more experienced peers would be helpful in navigating difficulties in caregiving. We identified different training methods, common experiences, and desired support from the responses in our affinity diagram as well.

From our secondary literature analysis, we knew that there was a clear commonality between the stress experiences of professional and non-professional caregivers, which allowed us to anchor our recommendations in processes related to the mitigation of burnout (rather than production of training materials). Non-professional and professional caregivers alike feel isolated when confronted with the inescapable rhythms of dementia care. The key difference between them is that workplace hierarchy adds an additional layer of institutional support, which non-professional caregivers do not have access to. Managers within the institution have the means to organize and coordinate employees, allowing the creation of different groups of affiliation (related to peer learning and teaching). Based on this, we believe that peer mentorship could be one of the most effective tools to close the gap between the mitigation of stress and preparedness.

IV.) RECOMMENDATIONS

RECOMMENDATIONS FOR BUSINESS

Our qualitative results indicated that most employees at the facility would appreciate additional support in the form of mentorship and a faster feedback cycle from management. Depending on scope and scale, we identified five approaches to addressing this employee need. We believe that when training uses a bottom-up approach, it has more potential to empower others, so our solutions for addressing this problem are focused on lean, low-cost models.

Above anything else, we would suggest pairing up new employees with established/senior employees. In order for these mentorship sessions to be effective, we would institute short weekly check-ins (1:1; 10-15min) with mentors to discuss learning process, on-the-job discoveries, and the degree of satisfaction/burnout. We came to this model for peer development because it is low-cost (minimal investment in terms of time and no required investment in terms of money), and would allow for relatively straightforward wins without sacrificing any time in a caretaker's already busy schedule. This practice can be instituted immediately, essentially whenever the personnel manager schedules new caretakers.

We would also suggest a monthly employee-only round table to foreground issues related to training, stress, and care. Practically, this looks like an hour-long loosely-moderated session, monitored by a representative that acts as management liaison. Having a safe space where employees can be free to

discuss needs related to caregiving is a productive way to build a rapport and increase social cohesion within the employee population. Building a feedback loop where concerns can be communicated to management allows those desires to be instituted more readily. Again, this has low-cost in terms of funds, but assembling together all of the caretakers at a particular time could be challenging to coordinate.

For a top-down approach, management can target new training methods (and their related subcategories, like mentorship and self-care techniques) to boost staff engagement and learning. If the institution is able to allocate more resources towards addressing employee needs, we suggest instituting quarterly training workshops that focus on particular subsets of diseases on the dementia spectrum. Having more experienced staff members lead workshops will allow employees to discuss their personal journey, coping mechanisms, and tools related to dementia care. Similarly, we would suggest that the in-house social worker with the organization conduct biannual seminars on self-care. Preparing employees in this way gives them more clear ways to approach the monolithic problem of dementia, allows them to feel empowered, and improves morale.

Finally, we would suggest organizing optional team-building events outside of work. This would allow employees to feel like they are part of a community, less isolated, and thus less prone to burnout. Ideally, this would happen in the form of a retreat sponsored by the employer. The option, as conceptualized here, is the most expensive and has the least clear possible outcomes.

RECOMMENDATIONS FOR IMPROVING STUDY

We could produce more nuanced and focused results if we modified our research methods. There are four key possibilities for improvement that we could take into account as we revisit our study. However, the effectiveness of all of these adaptations to our study are contingent upon our ability to gather additional resources, mostly in the form of time.

We could shift from a case study to a random sampling of professional caregivers at all elderly care facilities within the King and Snohomish county region. We would select facilities at random from within the region and use our survey instrument to gauge burnout and effectiveness of employee training. This would allow us to gain a more representative sample, rather than relying on connections provided by the snowball sampling method.

This proposed change is reliant on two separate parts. First, we would have to restructure our instrument, accounting for more filtering questions, additional demographic questions, and a different organizational structure overall. This could prevent confusion for participants in the survey, and allow us to make more inferences and draw interesting correlations since our population would be more diverse. Second, we would want to ideally gather a more robust selection of data, by augmenting the quantitative aspects of our survey. The most effective way for us to gather this information would be in the form of focus groups, and additional open-response questions. Collecting more data related to the subjective experience of caretakers (in addition to the MBI data) would create a more holistic picture of their needs.

Finally, if we wanted to chart out the effectiveness of training overall, we would attempt to implement the Kirkpatrick Model in a longitudinal study. The Kirkpatrick model is a long-term evaluative instrument for gauging effectiveness of training, based on 4 levels: satisfaction with training, degree of learning, behavioral change, and outcomes of training (Surr et al., 2017). Sticking with our population for a longer duration of time would let us make more inferences about where training is not addressing employee needs, and better conceptualize possible interventions.

APPENDIX A: Survey Instrument

The MBI is a self-rating scale, which addresses burnout according to, “emotional exhaustion (EE), depersonalization (DP) or cynicism, and reduced personal accomplishment (RPA)” (Truzzi, 2012). For consistency, the categories and scales of the abbreviated version are the same as the original (Maslach, 1996). EE refers to lack of energy and enthusiasm and the draining of one’s emotional resources. Depersonalization refers to the development of an indifferent, impersonal, or cynical attitude between oneself and the service recipient. RPA is a tendency to perceive one’s work negatively or as ineffective” (Truzzi, 2012).

* 2. Abbreviated MBI

	Every day	A few times a week	Once a week	A few times a month	Once a month or less	A few times a year	Never
I deal very effectively with the problems of my patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I treat some patients as if they were impersonal objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel emotionally drained from my work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel fatigued when I get up in the morning and have to face another day on the job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I've become more callous towards people since I took this job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I'm positively influencing other people's lives through my work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working with people all day is really a strain for me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't really care what happens to some patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel exhilarated after working closely with my patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 3. As a result of your orientation training, to what extent did you feel prepared to provide care to patients with dementia?

- ☐ Well prepared
- ☐ Somewhat prepared
- ☐ Not prepared at all

4. If answered "Not at all" for question 3, please select from the following choices:

- ☐ Material did not have a direct impact on daily care/was not practical.
- ☐ Minimal opportunities to use what I learned.
- ☐ Overall priorities related to care were different in real-world situations.
- ☐ Not enough social support to use techniques we learned.
- ☐ Prefer not to answer

* 5. As a result of your orientation training, to what extent did you feel prepared to manage job related stress?

- ☐ Well prepared
- ☐ Somewhat prepared
- ☐ Not prepared at all

6. If answered "Not at all" for question 5, please select from the following choices:

- ☐ Material did not have a direct impact on daily care/was not practical.
- ☐ Minimal opportunities to use what I learned.
- ☐ Overall priorities related to care were different in real-world situations.
- ☐ Not enough social support to use techniques we learned.
- ☐ Prefer not to answer

7. Do you have any suggestions for improving orientation training related to caring for patients with dementia?

8. Overall, are you satisfied or dissatisfied with your job?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

9. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

10. What is your gender?

- ☐ Female
- ☐ Male

APPENDIX B: Survey Consent Form

*** 1. UNIVERSITY OF WASHINGTON**

CONSENT FORM

SURVEY

Researchers: Amir Ali, Naga Soundari Balamurugan, Tiffany Ku, Kevin McCraney

Group Contact: tk11@uw.edu

PURPOSE OF STUDY

The purpose of this study is to explore the research question: to what extent does in person training, specifically new employee orientation impact burnout among professional dementia caregivers? This is commonly seen in caregivers who are exposed to a high level of stress at work, it includes emotional exhaustion, depersonalization, and low personal accomplishment according to Maslach et al. We want to examine how well this type of training might prepare professional caregivers with the ability to manage personal stress and interact with dementia patients.

STUDY PROCEDURES

This survey will take about 5-10 minutes to complete. The survey includes questions from the Maslach Burnout Inventory (MBI). MBI is considered a medical standard. The survey also includes questions to evaluate effectiveness of employee orientation training you have received. Thank you for your time and consideration.

Participation is voluntary and you may withdraw at any time. If you have any questions or hesitations about this survey, please contact us directly at: (206) 330-6156 or tk11@uw.edu.

RISKS, STRESS, OR DISCOMFORT

If you do not feel comfortable answering any of these questions you may end the survey at any time.

CONFIDENTIALITY OF RESEARCH INFORMATION

All of the information you provide will be confidential and will not be released to your employer. Respondent data will be used for educational purposes only. All data collected for this study will be destroyed on December 20 2017.

SUBJECT'S STATEMENT OF CONSENT

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, or if I have been harmed by participating in this study, I can contact one of the researchers listed on the first page of this consent form. If I have questions about my rights as a research subject, I can call the Human Subjects Division at (206) 543-0098 or call collect at (206) 221-5940.

Printed Name of Subject	<input type="text"/>
Initials of Subject	<input type="text"/>
Date (MM/DD/YYYY)	<input type="text"/>

APPENDIX C: MBI Scoring Criteria

These are the questions for the abbreviated MBI. Responses for the questions below are rated from 0 to 6, representing Never to Everyday respectively. Then responses for each question are added up and the total scores are calculated on a scale ranging from 0-18.

The score for emotional exhaustion (EE) is measured by using responses to the following statements:

1. I feel emotionally drained by my work
2. I feel fatigued when I get up in the morning and have to face another day on the job
3. Working with people all day is really a strain for me.

Higher scores indicate greater emotional exhaustion, and greater burnout.

Similarly, the score for Depersonalization (DP) is measured by the responses for the following statements:

1. I feel I treat some patients as if they were impersonal objects
2. I've become more callous towards people since I took this job
3. I don't really care what happens to some patients

Higher scores indicate greater depersonalization, and greater burnout.

And the score for Reduced Personal Accomplishment (RPA) is measured by the responses for the following statements:

1. I deal very effectively with the problems of my patients
2. I feel I'm positively influencing other people's lives through my work
3. I feel exhilarated after working closely with my patients.

Higher scores indicate greater personal accomplishment and less burnout.

APPENDIX D: Affinity Diagram Notes & Process

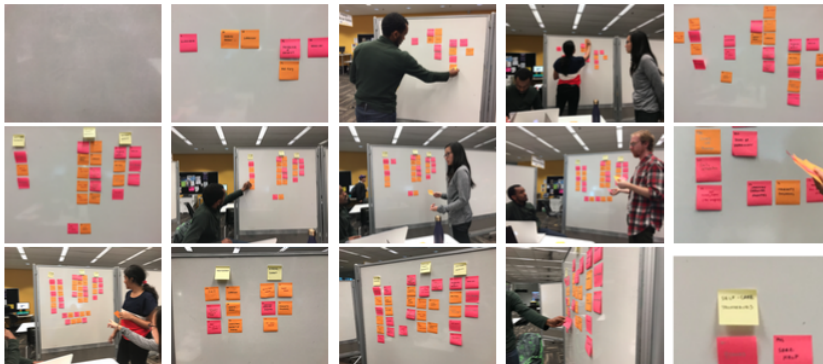
▪ Design Thinking

- Be reflective regarding biases and assumptions; think critically and out loud, so that others can understand the process
 - Listen to each group member, don't interrupt
- Allow categories to form freely
 - When establishing hierarchies, provide logical reasoning
 - Keep an open mind; there are no wrong answers
- Consider feedback and reach group consensus
- Document at each stage
- Iterate
- Have fun

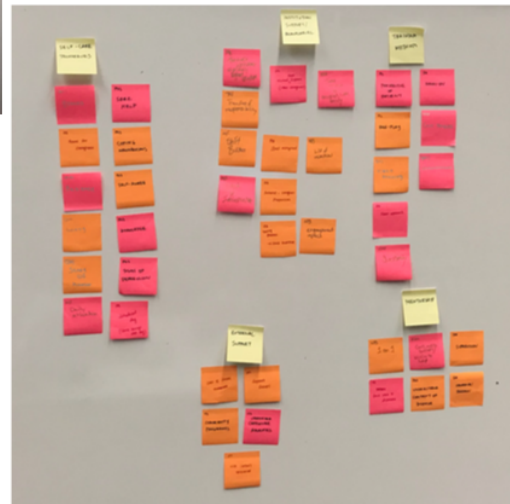
▪ Research

- Commonalities between our results (professional caregivers) and secondary data (family caregivers)
- Context of each response informs meaning

Design Thinking



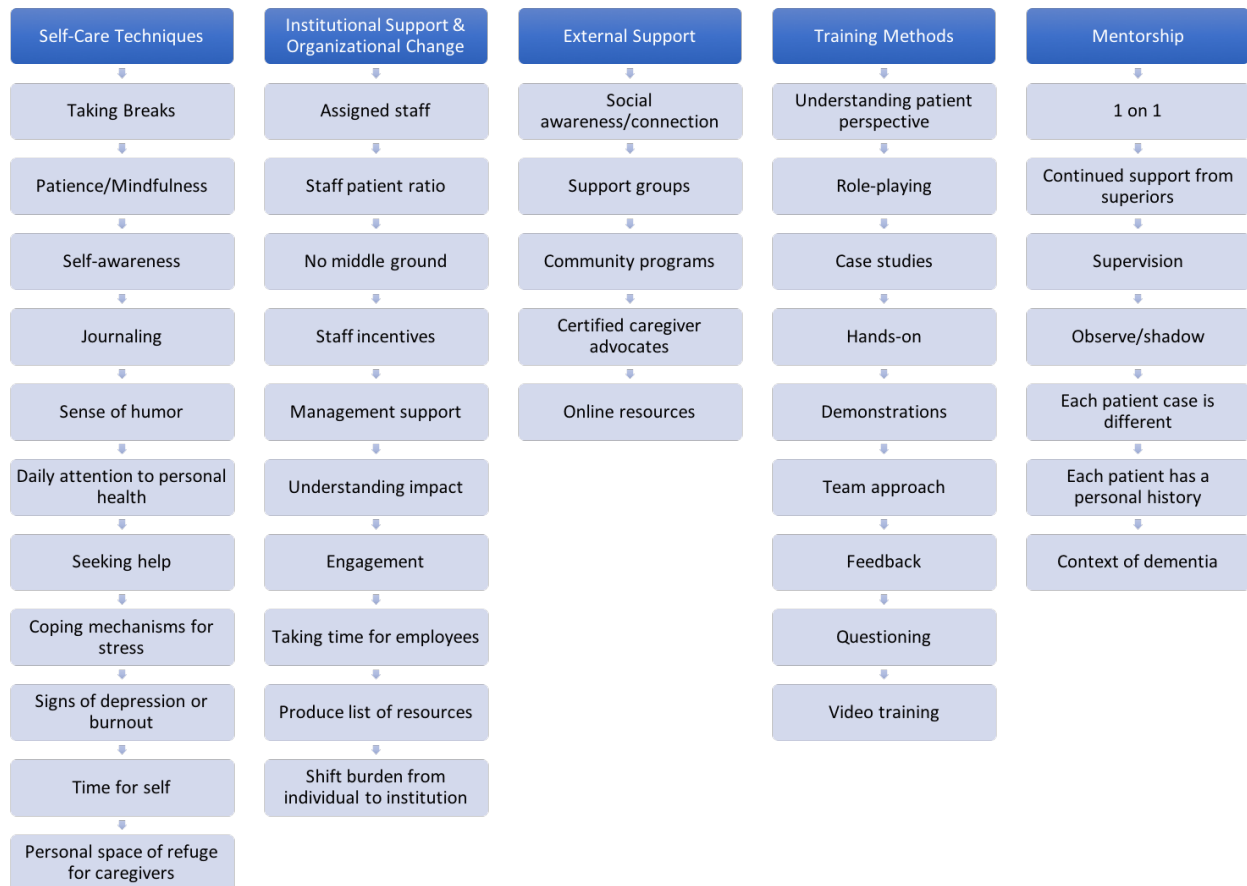
The Process



The Outcome

APPENDIX E: Final Affinity Diagram

To what extent does employee orientation training impact burnout among dementia caregivers?



REFERENCES

- “Dementia.” World Health Organization, *World Health Organization*, www.who.int/mediacentre/factsheets/fs362/en/.
- Douangratdy, Melinda, et al. “Brilliantly Battling Burnout: Practical Information, Tools, and Real-Time Exercises for Caregivers and Providers.” Psychiatric Rehabilitation Association and Foundation. 40th Annual Wellness and Recovery Summit, Atlanta, Georgia, www.psychrehabassociation.org/content/brilliantly-battling-burnout-practical-information-tools-and-real-time-exercises-caregivers.
- Gilhooly, K, et al. “A meta-review of stress, coping and interventions in dementia and dementia caregiving.” *BMC Geriatrics*, May 2016.
- Maslach, Christina & Jackson, Susan & Leiter, Michael & Pamphlet Collection (Library of Congress, YA. (1996). *The Maslach Burnout Inventory-Test Manual*. https://www.researchgate.net/publication/277816643_The_Maslach_Burnout_Inventory_Manual
- Pickard, Alison Jane., and Susan Childs. “Chapter 5: Starting the Research Process.” *Research Methods in Information*, Neal-Schuman, 2013, pp. 59–69.
- Poghosyan, Lusine, et al. “Factor Structure of the Maslach Burnout Inventory: An Analysis of Data from Large Scale Cross-Sectional Surveys of Nurses from Eight Countries.” *International Journal of Nursing Studies*, vol. 46, no. 7, July 2009, pp. 894–902., doi:10.1016/j.ijnurstu.2009.03.004.
- Surr, Claire A, et al. “What works in delivering dementia education or training to hospital staff? A critical synthesis of the evidence.” *International Journal of Nursing Studies*, vol. 75, Oct. 2017, pp. 172–188.
- Truzzi, Annibal et al. “Burnout in familiar caregivers of patients with dementia.” *Revista Brasileira de Psiquiatria*, Vol. 34, Dec. 2012, pp. 405-412.
- Van der Lee, J, et al. “Multivariate models of subjective caregiver burden in dementia: A systematic review.” *Ageing Research Reviews*, Vol. 15, May. 2014, pp. 76-93.