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How EI Got Its Groove Back

The Implementation of a Training Program in Emotional Intelligence at a Long-Term Care Facility

1. Introduction

We find ourselves in a golden age of caregiving. Technology now frees us to help patients at great distance, with unprecedented efficiency and with access to data that would have been the envy of generations past. Telemedicine, telehealth, robotic procedures, electronic medical records, fast-paced evaluation and treatment — all assume an increasingly central role in our practice.

But rapid advancement invites important questions.¹ Does faster care for more patients put caregivers' emotional awareness in jeopardy? Do we risk elevating algorithms and artificial intelligence over the art of empathic nursing? Characterized as they are by less direct interaction between caregiver and care seeker, by communication through email and text messages and by the remote monitoring of patients, might certain technological interventions cause us to deprioritize important person-oriented care skills? And, perhaps most practically, how do directors of nursing identify the adverse effects on junior staff of this paradigm shift and help restore the balance between care and convenience?

These are the concerns that animated our study. At our facility, we began to notice signs of what senior colleagues nationwide were sharing: reports of frustration among staff, negative feedback from residents, ever-increasing rates of attrition, even a troubling lack of trust among employees. We saw this as a call

¹ Bonnette, R. Rethinking technology's impact on empathy. Loyola University Chicago, School of Law. Summer 2014.

to action – an opportunity to get back to fundamentals and to ask a question that, at first blush, seems counterintuitive in the age of high-tech care: Can the principles of emotional intelligence (EI) help us resolve such issues and aid in the provision of best-in-class service?²

We sought to enlist the power of EI for junior and senior nursing staff and to integrate its teachings into key aspects of their delivery of care. We wanted to do this methodically and to ensure that the processes, people and policies were in place to achieve lasting, value-adding organizational change.³ We also needed a means of measuring the results of the implementation. We set out as well to extend the use of EI beyond the basic staff-resident experience. Aware of the demands of a busy clinical environment and of the stresses they place on relationships among staff members, we asked our entire clinical team to consider the applicability of EI to communications between managers and their direct reports and between non-managerial staff, all with a view to reinforcing our culture of caring and fostering the best results for our residents and their loved ones.

2. What is Emotional Intelligence?

When Salovey and Mayer coined the term, they revolutionized our thinking about interpersonal interaction.^{4,5} Nurses were always aware of the value of empathy in the care of patients, but few clinicians or academics had systematically described – or proposed techniques for measuring – the range of EI skills, principles and attitudes that add dimension to our practice.⁶ In the span of nearly thirty years, several definitions have made their way into the

² Brackett, MA., Rivers, SE., Salovey, P. Emotional intelligence: implications for personal, social, academic, and workplace success. *Social and Personality Psychology Compass* 5/1 2011. 97.

³ Issah, M. Change leadership: the role of emotional intelligence. *SAGE Open*. 2011.

⁴ Salovey, P., Mayer, JD. *Emotional Intelligence*. Baywood Publishing Co., Inc. 1990.

⁵ Kannaiah, D., Shanthi, R. A study on emotional intelligence at work place. *European Journal of Business and Management*, vol. 7, no. 24. 2015. 1.

⁶ David, L. Emotional intelligence (Goleman). *Learning Theories*. July 20, 2014.

literature.⁷ For our purposes, the description that offers the greatest general utility is the following:

The ability to harness emotions in sensing, understanding and responding adeptly to social cues in the surrounding environment for the purpose of interacting with others, solving problems and achieving higher performance.⁸

This results-driven definition has several virtues. It suggests that the central objectives of EI are constructive interaction, a focus on solutions and enhanced performance. In so doing, it encourages staff to develop a habit of mind conducive to team-oriented communication and *esprit de corps*, and to concentrate on measurable, beneficial outcomes in shaping their response to challenges.

In Goleman and Boyatzis' more granular definition, four specific attributes constitute EI: self-awareness, self-management, social awareness and relationship management. In turn, twelve competencies comprise these attributes, each vital to the full realization of EI capabilities (see Figure 1).⁹

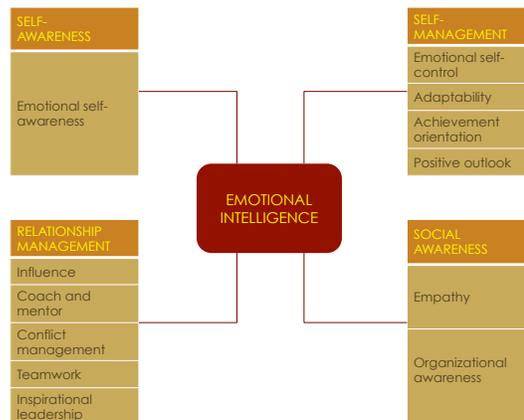


Figure 1. Components of emotional intelligence

⁷ See, e.g., Goleman, D. *Emotional Intelligence: Why It Can Matter More Than IQ*. Bantam Books. 1995.

⁸ Harmon, P. Course description: Emotional intelligence: an edge for leaders. Cornell University School of Industrial and Labor Relations.

⁹ Goleman, D., Boyatzis, RE. Emotional intelligence has 12 elements. Which do you need to work on? *Harvard Business Review*. February 6, 2017.

Just as important as EI's definition is the praise it continues to attract in multiple quarters. Faculty of the University of Oxford's psychology department suggest that "emotional intelligence is a key skill which has been associated with increased business success in sales, leadership, finance, health and other sectors. The source of this success has its roots in increased wellbeing, confidence and interpersonal skills."¹⁰ At Harvard, Laura Wilcox notes "evidence suggests that high emotional intelligence is a stronger predictor of success than technical skills. In fact, high EI bolsters the hard skills, helping us think more creatively about how best to leverage our technical chops."¹¹ Recognized for the value they bring to organizations and individuals, EI skills hold special promise as an instrument in the service of customer-centered clinical care.

3. Our Facility

Located in suburban New York, our 179-bed long-term care and short-term rehabilitation facility is one of seventeen operating statewide. A team of over two hundred staff members, we serve a population of retirees, eighty percent of whom are aged between 60 and 100 and twenty percent aged 59 and below. Residents hail from a wide range of countries and represent various levels of educational attainment. One third are women. Most are highly independent and maintain strong ties to family and a network of friends. A number benefit from the diverse range of rehabilitation services which we offer, including those related to the management of the effects of stroke. To gauge their satisfaction with our services, we request that residents complete a survey upon admission to our facility and upon exiting.

¹⁰ Pollock, J., Ross, A. Course description: Emotional intelligence for resilience, flexibility and growth. University of Oxford Psychology and Continuing Education Program.

¹¹ Wilcox, L. Blog article: Emotional intelligence is no soft skill. Director of Management Programs, Harvard Extension School. <https://shar.es/aX1rdy>

4. Core Principles and “Critical-to-Quality” Capabilities

In many respects, EI has long been integral to our approach to care. Determined to chart a resident-centered course for our facility, our leadership team early on articulated a set of core operational principles designed to inform our conduct as caregivers. These core principles comprise (i) a mission statement, (ii) six business values and (iii) ten service standards (see Figure 2).

4.1. Mission Statement

Our mission statement sets out the overarching purpose and care objectives of our facility:

[We] provide exceptional clinical care, coupled with a luxury experience, for our guests and their loved ones.

From this general prescription derives each of our values and service standards.

4.2. Values

Each of our facilities’ six values is expressed in narrative form. Value 1, for example, states, “[W]e are innovative with our approach to service, hospitality and clinical care. We are open to new ideas that could be more effective for our guests, their loved ones and our team members.” For purposes of this article, we summarize this standard by placing it under the rubric “innovation.” The remaining values may be summarized to include (ii) compassion, (iii) respect, (iv) listening/attentiveness, (v) loyalty and (vi) teamwork.

4.3. Service Standards

A number of our service standards are also expressed in narrative form. Standard 4 states, “Be the team member others want to work with.” We summarize this statement by referring to it as the “spirit” standard. The remaining standards include (ii) attitude, (iii)

connection, (iv) presentation, (v) customer-centricity, (vi) citizenship, (vii) engagement, (viii) responsiveness, (ix) drive and (x) stewardship.

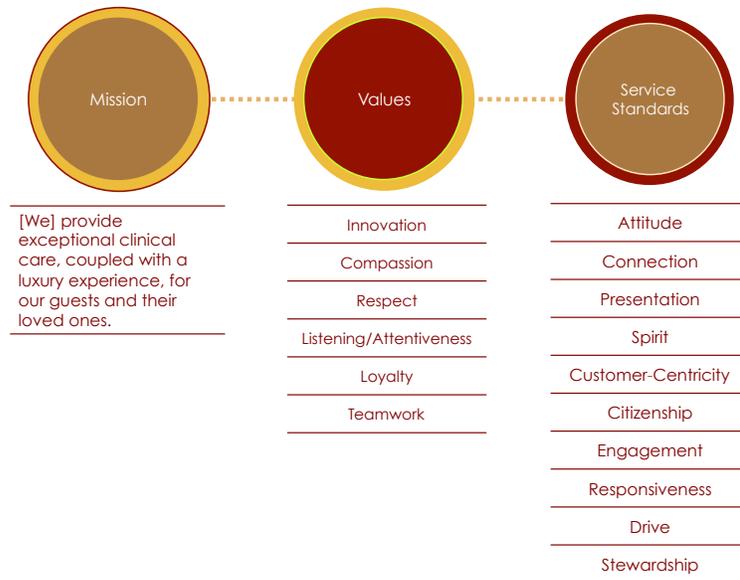


Figure 2. Facilities' core principles

Virtually all seventeen core principles rest squarely on a foundation of EI skills and depend on a working understanding of the elements of this form of intelligence. In their study of EI at the workplace, Kannaiah and Shanthi refer to a similar set of attributes and suggest a link between them and the elements of EI.¹²

¹² Kannaiah and Shanthi. A study on emotional intelligence at work place. 151-152.

4.4. Critical-to-Quality Capabilities

Critical-to-quality capabilities (CTQs) are those measurable processes, attributes or activities that form the crux of our work in healthcare. They include clinical expertise, a commitment to compliance and integrity, professional discipline and a results-oriented disposition.

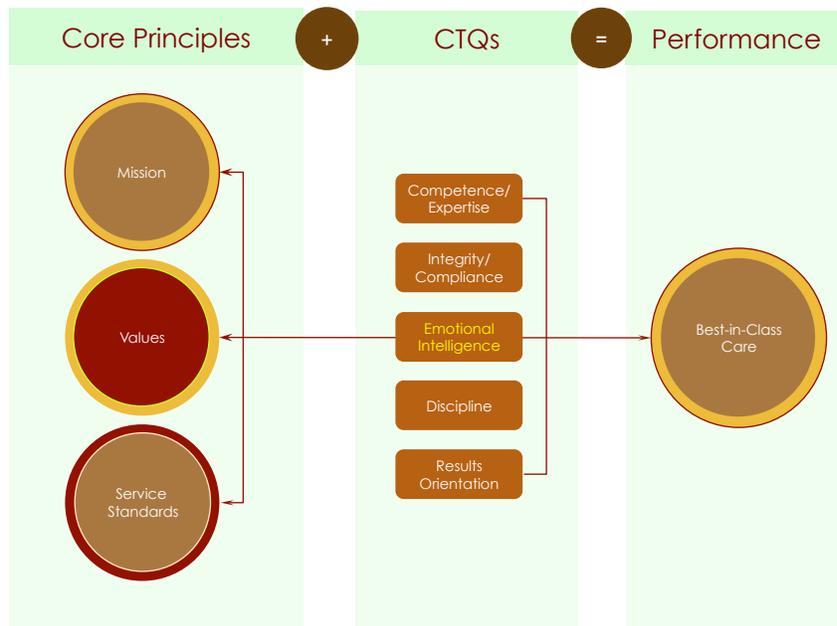


Figure 3. Core principles, "critical-to-quality" capabilities and performance

This study seeks to include the key elements of EI among the nurse's CTQs. We believe we ignore them at our peril. For our facility, the working mantra is that our core principles plus our CTQs – with EI featuring prominently among them – are vital to best-in-class performance (see Figure 3).

5. Methods

As a framework for our study, we looked to the disciplined, stepwise approach embodied in process improvement techniques used in other contexts (see Figure 4).¹³ This required that we (i) define the concern we wished to address, (ii) measure perceived deficiencies, (iii) analyze the root causes of any such deficiencies, (iv) improve related processes or policies and (v) implement controls to maintain these improvements.¹⁴

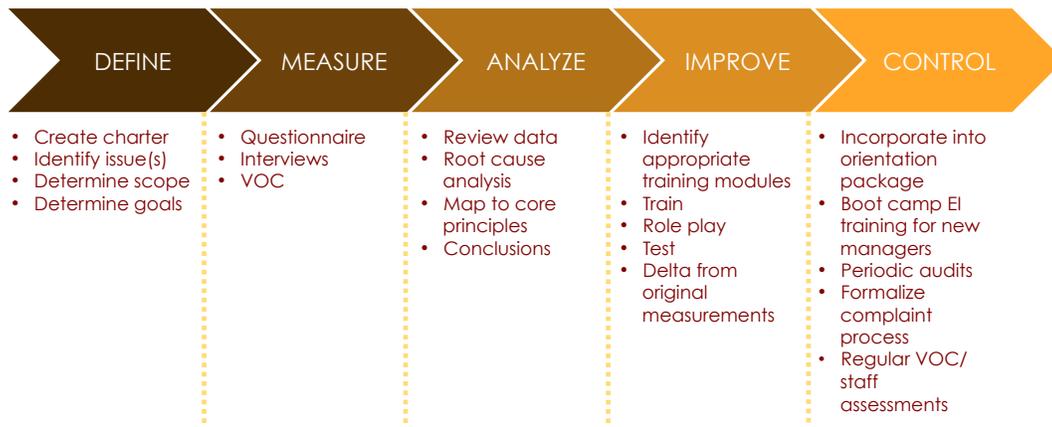


Figure 4. Approach to study by process step

5.1. Define

Our chief concern was any staff interaction with residents or team members that was not consistent with our core principles. We limited the scope of our study to this subject. Our project charter reflected this line of inquiry and set the following as our goal: A working environment conducive to (i) constructive, team-oriented communication and *esprit de corps* among staff and (ii) empathetic, client-centered behavior toward residents and their loved ones.

¹³ Peterka, P. The DMAIC method in six sigma. http://www.businessperform.com/articles/process-improvement/dmaic_method.html

¹⁴ DMAIC approach in lean six sigma. March 10, 2017. <https://www.6sigma.us/six-sigma-articles/dmaic-approach-in-lean-six-sigma/>

5.2. Measure

To set a baseline for our team, we employed EI assessment tools designed to allow for anonymous testing, controlled for bias. These tools were used by the full cohort of our employees immediately prior to their training sessions and again immediately afterward. The change in pre-training versus post-training test scores indicates the degree to which EI skills were acquired as a result of our program as well as any need for continued education. In addition to assessment tools, we surveyed the impressions of select residents and team members as to their experience in day-to-day interactions with staff and, as to staff, with each other. This component of our assessment is referred to as the “voice of the customer” (VOC). Taken together, test-based assessments and our VOC exercise provided valuable information about our team’s EI competency.

5.3. Analyze

We were interested in the root cause of any deficiency revealed by our self-assessment tools and VOC surveys. The results of this part of our study formed the basis for our decisions as to the steps we would consider for the enhancement of our EI capabilities.

5.4. Improve

Given our principal goals – empathetic, resident-centered service and constructive, team-oriented communication – we fashioned a program of training and communication designed to achieve these ends. Improvements had to be measurable and user-friendly, and each element would ideally be scalable across all seventeen of our facilities.

5.5. Control

Having implemented improvements, we worked to ensure that, on a going-forward basis, the appropriate systems and personnel are in place to maintain them. This included the

documentation of our work product, the maintenance of online training modules that are readily available to staff and the cross-training of junior staff members who can in turn mentor new employees.¹⁵

6. Discussion

At the heart of our facility's delivery of care is a set of core principles. To ensure that our performance is consistent with each, we actively drive the culture of caring that they express. With a changing workforce, new technological interventions and the evolving needs of our residents, our approach to instilling these values requires constant evaluation and reinvention.

During our most recent internal assessment, we detected a trend that colleagues around the country had been reporting: behavior among staff that did not comport with our standards. We considered it a matter of urgency to study and address this concern. We first reviewed our core principles with an eye to reinforcing their message and relevance. From the outset, we concluded that each core principle requires an understanding of – and a willingness among staff to embrace – the elements of EI. This became the impetus for introducing EI as a core competency.¹⁶

To establish team buy-in, we demonstrated the indispensability of EI. We discussed it with staff at all levels. We spoke about it at every meeting we attended. We presented it to our CEO and each of our regional facilities. In resolving certain complaints about staff interactions with residents and their families, we opted for EI-based solutions in lieu of punitive actions. We championed the building of EI competencies and conveyed their centrality to our mission statement, core values and service standards.

¹⁵ Zaki, J. Making empathy central to your company culture. *Harvard Business Review*. May 30, 2019.

¹⁶ Arora, S., Ashrafian, H., Davis, R., Athanasiou, T., Darzi, A., Sevdalis, N. Emotional intelligence in medicine: a systematic review through the context of the ACGME competencies. Blackwell Publishing Ltd. 2010. 750; 754-755.

Having secured company support, we developed a plan of education and communication, and launched with a program of EI assessment and training for all staff. We structured the implementation in multiple phases and by staff “cohorts.” Department heads were first; mid-level and junior staff followed. By the end of our initial phase, we had rolled the program out to 98% of the team.

To determine the degree to which our untrained team understood and practiced EI principles, we began by administering two self-assessment pre-tests. The first pre-test assessed the following categories of EI skill (see Figure 5):

1. Recognizing and Expressing Emotions (REM),
2. Understanding Others’ Emotions (UE),
3. Decision-Making (DM),
4. Managing Emotions (ME) and
5. Controlling Emotions (CE).

The second pre-test assessed EI competency by role (*e.g.*, whether CNAs’ capabilities differed from LPNs’)(see Figure 5). Overall, test results tended to vary according to staff members’ relative seniority. We concluded, preliminarily, that higher EI skill scores among senior staff likely correlated with greater professional experience in challenging settings and the development of coping strategies over time.



Self-Assessment

- Blind testing
- Controlled for bias
- Assesses EI competency by role and skill

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After a month we noted marked improvement in a number of the skills targeted for training

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- Provides baseline scores for untrained team
- Taken before and after training to show delta
- Based on Goleman methodology

Figure 5. Results of EI self-assessment pre-test by skill and by role

Having established our EI baseline, we initiated a comprehensive month-long training program centered around “the ability to monitor one’s own and others’ feelings and emotions, to discriminate among them and to use this information to guide one’s thinking and actions.”¹⁷ Importantly, the course emphasized that EI competency can be acquired, developed and refined, and that a well-balanced array of specific EI capabilities equips staff at all levels for leadership.¹⁸

As a team, we studied the role EI plays in our everyday thinking, decision-making, problem-solving and behavior. Properly deployed, it can positively influence our choice of words, bedside manner, tone of voice, body language and facial expression during in-person communication. It can enhance professional performance, improve relationships and the sense of trustworthiness among peers and help preserve physical and mental health.¹⁹ We learned the

¹⁷ Salovey and Mayer. Emotional Intelligence. 189.

¹⁸ Goleman and Boyatzis. Emotional intelligence has 12 elements. Which do you need to work on?

¹⁹ Brackett, Rivers, and Salovey. Emotional intelligence: implications for personal, social, academic, and workplace success. 95.

warning signs common to poor emotional reactions and techniques for managing triggers that elicit suboptimal responses.

To translate theory into concrete experience, we participated in a number of role-play activities guided by a set of facilitative ground rules. For each scenario, we abandoned negative criticism of colleagues in favor of constructive guidance and supportive “redirection.” Individuals were given an opportunity to share experiences in strict confidence, with complete candor and fully protected from disparagement.

To reinforce the key messages of our training, we now employ a focused communications plan. Throughout the facility we have installed signage designed to remind employees about the policies and procedures that underlie our commitment to EI. Practical guidance is also provided on computer screensavers and on pocket-sized cards that have been distributed to each employee. Going forward, we will incorporate EI training into our orientation package for new employees. New managers will be required to participate in a mandatory EI boot camp, and we will make resources available for continuous EI training and evaluation.

During and after our month of education, staff members practiced what they learned. We treated mistakes as opportunities to teach rather than occasions for punishment. Staff supported each other by intervening during challenging situations. In post mortem sessions, we identified warning signs and discussed strategies for diffusing conflict.

After a month, we noted marked improvement – anecdotal and in post-training test results – in a number of the skills targeted for training (see Figure 6). Where test scores declined after training, we recognize a need to understand causation and provide useful corrective interventions.

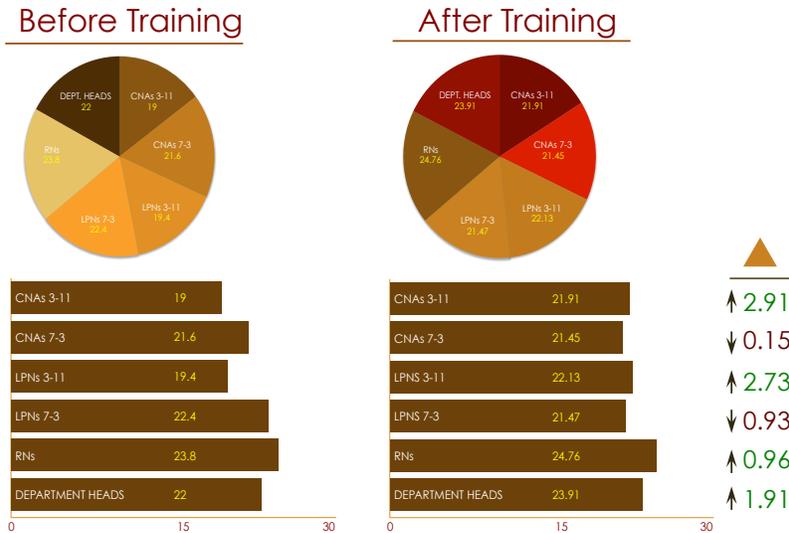


Figure 6. EI test results, by role, before and after training

We have received positive feedback from residents and staff alike. Team members have begun to display a greater spirit of cooperation and generally appear happier. Many express appreciation for the tools acquired through EI training. As an unanticipated collateral benefit, the increased interaction between managers and junior staff has had the effect of fostering meaningful mentorship.

Our EI training and communication plan is multifaceted. Over time we will continue to embed it even more deeply into our culture.²⁰ That overall performance has improved is encouraging and suggests that a commitment to augmenting EI competency adds value to the experience of our residents and the team that serves them.

7. Conclusion

In the clinical environment, where a host of competencies vie for top billing, EI is often denied its proper place. Having promoted greater EI awareness and implemented a program of training and communication to fortify our EI toolkit, we see measurable improvement in staff-resident interactions and team communication skills. As most sources

²⁰ Zaki. Making empathy central to your company culture.

note, EI has enabled our staff to make better decisions, manage our residents more effectively and improve relationships.²¹ We are also realizing meaningful dividends in the leadership and problem-solving spheres. We are not Luddites. There is enormous value to technologies that improve health outcomes. But our renewed emphasis on EI is a constant reminder to our team that, email, text messaging and remote monitoring notwithstanding, there is no substitute for well-managed person-to-person interaction. As with any transformative organizational change, we anticipate that the complete integration of EI will require continued, creative commitment. The results we have realized so far suggest this investment will repay the effort.

²¹ Raghubir, AE. Emotional intelligence in professional nursing practice: a concept review using Rodgers's evolutionary analysis approach. *International Journal of Nursing Sciences*, vol. 5, issue 2. 10 April 2018. 127.

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