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Mindfulness Based Self Care Toolkit for Psychiatric Healthcare Staff

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DNP Prospectus Draft

Mindfulness Based Self Care Toolkit for Psychiatric Healthcare Staff

Harkirat K. Bajwa

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NURS-749

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Abstract

**Background:** Healthcare professionals (HCPs) are at high risk of stress, burnout, and compassion fatigue (CF). Nearly half of the doctors and one-third of the nurse’s experience burnout in the United States. The risk became more evident during coronavirus disease (COVID-19) pandemic as more patients and healthcare providers seek mental health services.

**Problem:** The physical and mental health of HCPs is impacted by burnout and CF, leading to increased practice errors, decreased patient safety, and negative effects on HCPs’ physical and mental health. Mindfulness practice is beneficial to reduce stress and burnout in various populations, but HCPs have poor knowledge about mindfulness and its benefits. Also, Mindfulness-based self-care measures are not promoted in HCPs.

**Context:** The staff at psychiatric hospital (mental health technicians, nurses, case managers, psychiatrist) who are at high risk of BO, CF and stress would be educated about mindfulness-based self-care strategies by a toolkit. The needed support from stakeholders at hospital is acquired by various stakeholder management strategies.

**Proposed Interventions:** A mindfulness-based self-care toolkit would be implemented along with training session about various mindfulness strategies. Other resources like flyers, mindfulness themes in units, cheer up sessions for staff would be implemented to encourage them to practice mindfulness.

**Proposed Outcome Measures:** Staff’s knowledge about mindfulness, use of mindfulness as a means of self-care, and ease of use of toolkit would be measures by post intervention questionnaire.

**Keywords:** psychiatric nurse, psychiatrist, clinician, healthcare providers, mindful* burnout, stress, compassion fatigue
Mindfulness Based Self Care Toolkit for Psychiatric Healthcare Staff

Background

Healthcare professionals possess values of compassion and empathy, which can put them at high risk of CF, stress, and burnout (Cocker & Joss, 2016). Compassion fatigue is described as the “cost of caring” for others in emotional pain (Figley, 1995). Stress is an “imbalance between perceived external or internal demands and the perceived personal and social resources to deal with them.” (Lazarus & Folkman 1984, as cited in Webber, 2001). Extended exposure to stress can lead to burnout (BO) characterized by emotional exhaustion, depersonalization, and lack of accomplishment (Cocker & Joss, 2016). Nearly half of the physicians and one-third of the nurses’ experience BO in the United States (Reith, 2018). Attributes of CF and BO are prolonged exposure to the trauma and stress of clients, long working hours, and care burden on healthcare professionals. However, mental health professionals (MHPs) are at increased risk of burnout due to additional and innate stressors like violent and unpredictable patients (Maslach & Leiter, 2016).

Helping, healing, and listening to others provide immense compassion and satisfaction. However, persistent dealing with and confronting traumatic events leads to compassion fatigue in MHPs (Mangoulia et al., 2015; Breger et al., 2011). Additionally, the U.S. Bureau of Labor Statistics (BLS, 2020) reports that 73% of nonfatal workplace injuries (WPV) injuries happen to healthcare workers and MHPs account for most of these injuries, with a shocking incident rate of 124.9/10,000 employees in 2018 (BLS, 2020). Higher physical assaults on psychiatric nurses lead to occupational stress, burnout, and PTSD among psychiatric nurses (American Nurses Association [ANA], 2015).
Problem Description

BO and CF impact providers' physical and mental health leading to feelings of hopelessness and decreased job efficacy and productivity (Salvation et al., 2017). It directly impacts the quality of care delivered to the clients, adverse patient outcomes, patient safety, increased practice errors, and relationship conflicts among professionals (Magnolia et al., 2015; Suleiman-Matos et al., 2020; Tawfik et al., 2019; Teng et al., 2010). The high turnover rate and increased sick calls due to BO increase the healthcare cost of recruiting and retaining employees. Stress can contribute up to 40% of staff turnover and 80% of work-related injuries (Safaris et al., 2016). The high level of CF, BO, and stress experienced by MHPs and its devastating effects on themselves, patients, and the healthcare system, calls for vital interventions to care for those who care for others.

Literature shows that regularly practicing self-care interventions enhance MHPs’ job performance (Smith, 2017). One such intervention is Mindfulness-Based Stress Reduction (MBSR), a technique of intentionally paying attention to the present and cultivated through meditation. Mindfulness is described as increasing awareness of present moments without judgement, and is cultivated through practice (Cresswell, 2017). Mindfulness has been used in various workplaces and a variety of populations, i.e., students, veterans, and patients with chronic illnesses, to reduce stress (Bostock et al., 2019; Green & Kinchen, 2021). Although HCPs have shown a keen interest in mindfulness-based self-care, almost 81% of healthcare staff do not know about mindfulness and its benefits (Ameli et al., 2020; Seidel et al., 2021). This project would aim to implement a mindfulness-based toolkit to promote self-care in psychiatric healthcare staff in two units of the psychiatric hospital.
Setting

The clinical setting is an acute psychiatric hospital located in Fremont, California. The 148-bed fully accredited hospital provides treatment to patients with a wide range of mental health illnesses, like depression, anxiety, bipolar disorders, borderline personality disorders, schizoaffective disorders, adjustment disorders, attention deficit hyperactivity disorders, and drug addiction problems. The patients in the acute psychiatric hospital can exhibit signs and symptoms of suicidal or homicidal behavior, poor impulse control (aggression and assaultive behavior), responding to internal stimuli (hallucinations), and behavioral manifestations (i.e., manipulative behavior). The staff providing direct care to the patients at the hospital includes mental health technicians (MHTs), nurses, case managers, and psychiatrists. The psychiatric hospital staff is expected to implement various behavior management strategies for the patients, including verbal de-escalation, therapeutic communication, empathetic listening and conducting group therapy sessions.

Due to a stressful working environment, the hospital has a high sick call rate and staff turnover rate. Currently, an Employee Assistance Program is offered to staff who need any mental health support as per guidelines of the Occupational Safety and Health Administration (OSHA) (OSHA, n.d.). However, no self-care or preventative strategies are promoted for staff to prevent stress and resulting burnout and CF.

Specific Aim

This project aims to develop, implement, and evaluate a mindfulness-based self-care toolkit for psychiatric healthcare staff (nurses, mental health technicians, case managers, psychiatrists) by August 2023. Following are the three objectives of the project.1) Psychiatric healthcare staff will have a 25% or greater increase in knowledge about mindfulness as
compared to baseline by August 2023. 2) 50% or greater psychiatric healthcare staff will use mindfulness-based self-care strategies by August 2023. 3) 50% or greater psychiatric healthcare staff will show competency in using a mindfulness-based self-care toolkit by August 2023.

**Available Knowledge**

**PICO(T) Question**

A question is created specifying Population, Intervention, Control, Outcome, and Timeframe (PICOT) to drive the database search for finding the evidence related to developing a mindfulness-based self-care toolkit. However, the time frame is not applicable for the interventions under study. Therefore, based on PICO(T) guidelines, the literature search was focused on getting the answer to the following question: in healthcare professionals, does practicing mindfulness-based strategies compared to no interventions reduce the rate of burnout, stress, and compassion fatigue over a period of 6 months?

**Search Methodology**

An in-depth search was conducted to find evidence about the effects of mindfulness on stress, compassion fatigue, and burnout from various sources. First, an extensive search was done in the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and PsycINFO. The keywords used to search the evidence in CINAHL and PsycINFO were mental health professionals OR psychiatric nurses* OR psychiatrist* OR clinician OR healthcare providers AND mindful* AND burnout OR stress OR compassion fatigue AND systematic review OR meta-analysis OR randomized controlled trial*. The initial yield was 358 articles. Moreover, peer-reviewed studies published in the last five years in English were considered. The final search retrieved 178 articles. Mesh terms used to explore PubMed were: Mental health professionals OR psychiatric nurses OR psychiatrists AND mindfulness AND
burnout OR stress OR compassion fatigue. Initially, PubMed yielded 1414 results. Then, a more rigorous search methodology was used by looking for peer-reviewed meta-analyses, randomized controlled trials, and systematic reviews published in the last five years. The final search yielded 26 articles.

The following journals were also explored to seek evidence using the same search terms: Journal of Psychiatric and Mental Health, Mindfulness, and Holistic Nursing Practice. Moreover, the reference lists of the included articles were also searched manually to find the relevant studies. Inclusion and exclusion criteria were used to find the most relevant studies. Inclusion criteria were the studies reporting the effectiveness of mindfulness-based self-care techniques for mental health professionals in psychiatric settings. However, similar populations like healthcare professionals and clinicians were also considered. Upon review, almost 100 duplicate studies not targeting the required population and interventions were excluded. Finally, ten articles were chosen that met the criteria. The articles were further appraised for quality and level of evidence on the Johns Hopkins Evidence-Based Practice (JHEBP) appraisal tools (Dang et al., 2022). Per the JHEBP tool, two randomized clinical trials provided level I, high-quality evidence; five studies provided level II, and two qualitative studies delivered level III good-quality evidence (Appendix C). One mixed-method study resulted in poor quality quantitative but good quality qualitative evidence because of the high dropout rate.

**Integrated Review of Literature**

While reviewing the literature, the following themes emerged: the types of mindfulness used, the effect of mindfulness practice on each burnout, stress, compassion fatigue, and state of mindfulness, factors affecting the practice of mindfulness strategies by HCPs.
**Types of Mindfulness:**

The various forms of mindfulness strategies used in literature ranged from the traditional MBSR and other forms based on MSBR (Ameli et al., 2020; Askey-Jones, 2018). The traditional MBSR was developed by Jon Kabat-Zinn for stress reduction. MSBR requires 2.5- to 3-hour in-class practice sessions daily and one full-day silent retreat within 45 minutes of daily self-practice recommendation (Kabat-Zinn, 2003). The brief mindfulness program offers 5-session program with 1.5 hours/class and home practice recommendations (Askey-Jones, 2018). Other forms of mindfulness used in literature were practicing mindfulness yoga, breathing and voluntary pledges (Hilcove et al., 2021; Horton-Dustech et al., (2020); Owens et al., 2020; Wampole & Bressi, 2020).

**Effects of Mindfulness**

**Effects on Burnout.** Burnout was measured in the studies by Maslach burnout inventory (MBI) which evaluates three components of burnout: emotional exhaustion (EE), depersonalization, and personal accomplishment (PA). Improvement in burnout is determined by decreased scores on EE, depersonalization, and higher scores on PA. MBI is widely used in research to measure burnout as it has a high degree of reliability, validity, and internal consistency with a Cronbach’s alpha coefficient of 0.85 (Askey-Jones, 2018).

Literature suggests that various forms of mindfulness-based strategies like MBSR, brief mindfulness training ranging from a four-hour workshop to four-week programs, and mindfulness-based yoga significantly reduced burnout in HCPs (Ameli et al., 2020; Askey-Jones, 2018; Hilcove et al., 2021; Suleiman-Martos, 2020). Mindfulness positively affected all three components of burnout, i.e., EE, PA, and depersonalization. Regular mindfulness practice helped participants to accept their emotions without judgment, thus relieving emotional exhaustion and
increasing the sense of PA (Ameli et al., 2020; Suleiman-Martos, 2020). In addition, increased awareness of present moments contributed to decreased depersonalization (Wampole & Bressi, 2020). Moreover, a statistically significant negative correlation between mindfulness and burnout was determined (Askey-Jones, 2018). However, the quantitative results of one study remained inconclusive as the small sample size did not allow the use of inferential statistics (Wampole & Bressi, 2020).

**Effects on Stress.** Stress levels were measured by the perceived stress scale in quantitative studies, while other studies showed qualitative data. Mindfulness interventions significantly reduced stress levels, and the effect was retained after a significant amount of time, ranging from 13 weeks to six months (Ameli et al., 2020; Ruiz-Fernández et al., 2020; Sarazine et al., 2021). In addition, mindfulness interventions helped the HCPs reevaluate how they perceive stress and helped them learn positive coping skills to deal with it. For instance, HCPs opted to pause for a moment, taking deep breaths instead of crying when stressed. Moreover, decreased stress levels resulted in better sleep quality, boosted confidence, and emotional stability in HCPs leading to a better focus on patient care (Ruiz-Fernández et al., 2020; Wampole & Bressi, 2020; Wu et al., 2021). Furthermore, the positive effect of mindfulness on HCPs’ stress levels has been validated by brain images and saliva cortisol levels change after mindfulness practice (Suleiman-Martos et al., 2020).

**Effects on Compassion Fatigue.** Mindfulness practice via mindfulness pledges and mindfulness breathing has increased compassion and empathy in HCPs (Horton-Deutsch, 2020; Owens et al., 2020; Ruiz-Fernández et al., 2020). Mindfulness pledges are based on Project7, a set of seven mindfulness-based pledges developed by Robert Varney (Horton-Deutsch, 2020). Staff voluntarily chose a pledge for each day to be more mindful. Moreover, mindfulness
practice fosters an increase in self-awareness, kindness, and self-compassion leading to kindness and compassion towards others, compelling a positive change in the work environment, and better relationships with coworkers (Horton-Deutsch, 2020; Owens et al., 2020; Ruiz-Fernández et al., 2020).

**Effects on the State of Mindfulness.** Mindfulness training helps the HCPs to be more mindful of present moments and validate their emotions without judgment. The results in studies are consistent that the state of mindfulness does not increase immediately after intervention but significantly improves after 13 weeks and six months of follow-up (Ameli et al., 2020; Askey-Jones et al., 2018; Sarazine et al., 2021). Moreover, HCPs expressed feeling more aware of themselves, resulting in a positive relationship with colleagues and patients after practicing mindfulness (Wampole & Bressi, 2020).

**Factors Affecting the Use of Mindfulness Training Strategies**

The time commitment to attending the traditional eight-week MBSR was the main reason for high drop-out rates in studies. HCPs found it hard to go offsite and attend mindfulness-based training (Ameli et al., 2020; Sarazine et al., 2021; Seidel, 2021). Additionally, the difference in shift timings, and day offs made it hard for nurses to consistently participate in onsite mindfulness-based training programs (Sarazine et al., 2021.; Wampole & Bresssi, 2020). Furthermore, it is hard to determine if the participants practiced mindfulness at home for recommended amount of time.

**Synthesis of Literature**

Literature suggests that HCPs working in different healthcare settings like intensive care units, mental health settings, and community hospitals have benefited from practicing mindfulness regularly. There is consistency in the literature showing that regular practice is the
key to getting the best benefits from mindfulness programs. However, the small sample size and high dropout rate in some studies resulted in lower quality of evidence and decreased the generalizability of studies. The high drop-out rate can be attributed to different shift timings and time commitment to learning mindfulness in HCPs. However, Dr. Kabat-Zinn (2005) suggested that a practicing a little possible mindfulness can have a profound impact on learning mindfulness and quality of next moment. So, conducting the mindfulness intervention in scheduled shift timings, reducing the length of interventions, and promoting the self-practice of mindfulness can help make the mindfulness practice more feasible for HCPs. Moreover, the studies in this literature review did not discuss staff’s baseline psychological resilience levels and the use of self-care measures other than mindfulness like sleep hygiene, good nutrition, etc., which might have affected the results (Leão et al., 2017).

The effect of mindfulness on HCPs’ burnout and stress is widely studied in the literature with high-quality studies. Qualitative studies mainly examine evidence of mindfulness’s effects on compassion levels. However, higher compassion levels have reciprocal relation with compassion fatigue (Wu et al., 2021). But there is a paucity of high-quality evidence studying mindfulness’ impact on compassion fatigue in HCPs. In a nutshell, there is compelling evidence that mindfulness helps HCPs reduce burnout and stress in HCPs. However, more high-quality research is needed with enough sample size to determine mindfulness’s effect on compassion fatigue.

**Rationale**

The conceptual framework for the project is a construct of two theories: the transactional model of stress and coping (TSC), and diffusion of innovation (DoI). The combination TMSC
and DoI and is a conducive framework to guide human behavior in response to stress and adopting new behavior.

Lazarus & Folkman (1984) developed TSC and explained that response to stress results from primary and secondary appraisal of the situation (Appendix E). The primary appraisal determines whether the problem is relevant/ non-relevant or harmful/gainful. Appropriate and harmful situations drive a secondary appraisal that analyses available resources and situational demands. A negative stress response occurs if available resources are less than situational demands. On the other hand, available resources lead to a positive stress response which can either change the situation or the relationship with the situation. Furthermore, repeated appraisals with positive resources lead to less stress and a change in coping styles. The model has been used in research for explaining stress responses and developing coping strategies for patients and family members with physical and mental chronic illnesses (Asadi Shavaki et al., 2020; Avcıoğlu et al., 2019; Lee & Poole, 2005). This theory drives the literature search to find the appropriate strategies for managing HCPs' stress, CF, and BO.

The DoI, developed by Rogers (2003), explains that adopting an innovation/idea is a process. Some people will adopt the new idea earlier than others, whereas some individuals can be too conservative in adopting an innovation leading to six categories of adopters (Appendix D). Moreover, an adopter would pass through stages of awareness, persuasion, decision, implementation, and continuation for ultimately adopting the innovation. DOI has been used worldwide to spread the new technology to patients, students, and organizations (Emani et al., 2018; Zhang et al., 2015). Researchers argue that channels of communication, adopters’ knowledge and attitude, and innovation’s convenience are significant factors impacting the adoption rate of innovation (Mohamadi et al., 2018; Zhang et al., 2015). Since MBSR can be less
feasible because of high cost and time commitment; implementation of an easy-to-follow toolkit along with brief training on using various mindfulness strategies would increase adoption of mindfulness as a method of self-care among psychiatric staff.

**Methods**

**Context**

Maintaining status quo (no interventions to promote self-care) among psychiatric hospital staff (MHTs, nurses, case managers, and psychiatrist) would increase the risk of BO, CF, and stress, among staff and resulting negative effects on patient care. The mindfulness-based self-care toolkit would benefit the psychiatric hospital staff by disseminating the evidenced based stress reduction modality i.e., mindfulness practice. The project would be implemented over 15 months, starting from the planning to the evaluation phase. The implementation phase would be for three months.

The critical stakeholders for the project are the chief executive officer (CEO), nurse managers, nurse educators, director of nursing (DON), and the population under study (Nurses, mental health technicians, case managers, and psychiatrists) (Appendix F). These stakeholders must be informed and satisfied with the project's needs on time.

**Proposed Intervention**

The proposed intervention would be to implement the mindfulness-based self-care toolkit to promote self-care among psychiatric hospital staff. A training session to would be held for using the toolkit. The word would be spread by posting pamphlets about the training session and project in the unit. The focus would be on two units with high turnover rate, but any other staff from other units would be welcomed to join. The date of the training session
would be sent out via emails and the announcement platform used in the psychiatric hospital. This would be done with the help of the nurse educator.

The training session would focus on the prevalence of BO, CF, and stress and their effects on MHPs. Also, various mindfulness-based strategies would be taught along with handouts on mindfulness-based strategies. Moreover, posters about mindfulness strategies would be posted around the units. Staff would be educated to self-practice mindfulness for three months. Follow-up sessions would be provided monthly for three months regarding any questions about toolkit and to encourage the staff to practice mindfulness. Evaluation of knowledge will be done at the end of the three months about mindfulness strategies. Also, using mindfulness for self-care and feedback on the toolkit would be collected and discussed with stakeholders for a possible project continuation in other units.

*Gap analysis*

Mindfulness is an effective strategy for managing BO, stress, and CF. Also, the best practice recommendation by American Nurses Association (ANA), American Medical Association (AMA), and World Health Organization (WHO) recommends promoting self-care to prevent BO and stress in various HCPs like nurses and doctors (ANA, 2017; Baxter, 2022; WHO, 2020). However, no self-care resources are currently being provided to the psychiatric hospital staff. Moreover, evidence shows that almost 81% of healthcare staff do not know about mindfulness and its benefits (Amelia et al., 2020; Seidel et al., 2021). Therefore, to fill in the gap between evidence and current practice, a mindfulness-based self-care toolkit would be developed and provided to the staff at the psychiatric hospital (Appendix G).
**Work Breakdown Structure and GANTT chart**

The project will be implemented in four phases: planning the project, designing, implementing, and evaluating the mindfulness-based toolkit (Appendix H). The planning part will accomplish the project’s site and related tasks. A presentation about the project’s needs would be presented to high-power stakeholders like the chief executive officer (CEO), director of nursing, and nurse educator. The needed formalities to secure the project site would also be initiated, i.e., the affiliation agreement between the project’s site and the School of Nursing and Health Professions, University of San Francisco. The deliverable of this phase would be getting a letter of support from the CEO. Once the site has been secured, the toolkit development will start. All the materials for the mindfulness-based toolkit, like posters, badge buddies, flyers, and power point presentations will be prepared and designed based on the best evidence from the literature. Also, the dates of staff training will be finalized.

Next, during the implementation phase, the staff’s pre-interventional knowledge of mindfulness-based strategies will be assessed via a questionnaire followed by a training session, posting the posters in the units and staff lounge, and giving away badge buddies with mindfulness-based strategies. During this phase, staff would be encouraged to ask questions or concerns about the toolkit/ mindfulness practice via a contact email. Finally, after three months, the post-intervention knowledge of staff about mindfulness-based strategies, use of mindfulness as a source of self-care, and feedback about the toolkit will be collected and analyzed in the evaluation phase.

The project’s timeline shows that planning would be finished by December 2022 (Appendix I). Various educational materials would be designed by April 2023 followed by implementation in summer 2023. Finally, evaluation would be done by December 2023.
**SWOT Analysis**

The toolkit implementation comes with certain internal strengths and weaknesses and external opportunities and threats (Appendix J). The primary strength of the toolkit is that it would be low cost, easy to use, and readily accessible for psychiatric hospital staff. Moreover, no mandatory time commitment is needed to practice and learn mindfulness in a structured environment. However, the regular practice of mindfulness-based strategies presented in the toolkit would be required by staff. But the team might show less interest in using or practicing mindfulness. Although this phenomenon can be explained according to Roger’s theory of diffusion of innovation, only 2.5% to 13.5% of people adopts a new intervention initially. In contrast, most people would be late adopters or laggards (Rogers, 2003). However, some of the staff might prefer other forms of self-care strategies over mindfulness; it can pose a weakness to the toolkit’s success.

A worldwide shift of healthcare organizations to promote the mental well-being of healthcare providers by providing a variety of self-care resources can be an opportunity for toolkit implementation (Blake et al., 2020; Sales et al., 2019). Moreover, regulatory bodies like ANA, AMA and WHO have promoted the use of self-care and a healthy work environment to combat BO and stress in HCPs (ANA, 2017; Baxter, 2022; WHO, 2020). These factors can motivate the organization leaders to adopt the project faster. However, the wide access to mindfulness-based apps and the use of other forms of available self-care resources by staff like physical activity and yoga might threaten staff’s adoption of the toolkit.

**Proposed budget**

The projected budget for the project would include material costs to develop the toolkit and training session costs for 30 staff (Appendix K). Material cost would consist of time to
design the toolkit (30 hours) and printout cost for posters, flyers, badge buddies, and customized badge holders. The total material cost would be $2380. The training session would be two and a half hours long (one-hour initial training and half-hour monthly sessions for three months). The pay rate for the trainer is $68/hour. The average pay for staff would be $55/hour. The total cost comes up to $3920. The total cost would be $6300. The cost of recruiting the employees would balance the cost. Various sources indicated that the average cost of recruiting a Registered nurse is $37,000 and up (Cornell & Vaughn, 2020). The toolkit would be paid for even if the staff turnover decreased by 1%.

**Communication Plan/Matrix**

The communication needed for the project would be stakeholder, training, and evaluation meetings (Appendix L). The initial meetings would be done with high-power stakeholders like the CEO, DON, nurse educator, and nurse managers for a presentation about the project and to put forward a project timeline. Next, a face-to-face meeting with charge nurses would be done to get the necessary support for encouraging staff to practice mindfulness. The training meeting would include a one-hour training session for various mindfulness strategies and a monthly half an hour follow-up session with staff. Finally, two evaluation meetings would be to get feedback on the toolkit and a high-power stakeholder meeting to discuss the project's outcome and possible continuation in other hospital units. All the meetings would be conducted either zoom or face to face depending on the feasibility.

**Proposed Outcome Measures and Analysis**

Measuring the outcome and knowing if the change is an improvement is crucial to the continued implementation of the Quality improvement project (Institute of healthcare improvement, 2022). Quantitative and qualitative methods would measure the outcomes of the
project. A questionnaire would measure the staff’s knowledge and use of mindfulness strategies for self-care. The questionnaire would be a Likert scale where participants can rate their knowledge about various mindfulness strategies, use of mindfulness for self-care, and ease to use of toolkit on a scale of one to five points. Moreover, open-ended qualitative questions would be added to get feedback on the toolkit.

The data for the project would be collected by surveys using Qualtrics. SPSS software and the word cloud would be used for quantitative and qualitative data. Descriptive statistics would be used to describe the demographics of staff. Pre-intervention and post-intervention scores on knowledge and use of mindfulness for self-care would be compared by dependent t-test.

**Ethical Considerations**

The project is not active research but an evidenced based change of practice project. However, the ethical standards related to participants’ privacy would be maintained throughout the project. Also, the project will support the Jesuit values of “Educating the whole person.” Mindfulness self-care education for nurses will promote nurses’ spiritual, intellectual, and emotional intelligence, leading to their growth as a whole person.

Moreover, the American Nurses Association (ANA) (2015) recognizes CF as detrimental to nurses' personal and professional life. ANA has provided immense importance to the 'personal health, safety, and well-being in provision 5.2 of the *Code of Ethics with Interpretive Statements*. Therefore, providing empirically proven self-care resources to psychiatric staff would support the ANA code of ethics.
Discussion

Limitations

The major potential risk for the project’s implementation can be a small sample size or a high participant dropout rate. The reason can be the frequent floating of staff on another unit or different shift timings of the staff. Another potential barrier could be lower interest levels of staff in practicing mindfulness. The mitigation plan would be to choose the units in the hospital with stable and consistent staff and to have some staff members on each shift as cheerleaders for mindfulness practice. Moreover, incorporating cheer-up sessions during monthly stakeholder meetings, a gratitude board in the units, and mindfulness-based themes/motivational quotes would hold staff’s interest in the project. The motivational themes would be displayed on the change of shift report and gratitude board. Also, personalized badge holders reflecting ‘mindfulness’ would be given out to the staff. The strategies mentioned above would help keep the staff interested in the project.

Conclusions

Once implemented, the project aims to teach the importance of self-care and to learn the mindfulness-based strategies for self-care among the staff working in the acute psychiatric hospital. Moreover, changes in the toolkit would be incorporated if indicated by the pilot project’s evaluation, and the toolkit would be implemented in other hospital units. Furthermore, a regular session on the importance of self-care and mindfulness-based toolkit in new hire orientation and annually would be imperative to get the best use of the evidence. In addition, trained leaders can be a great resource to relieve stress in staff through encouraging mindfulness practice and loving-kindness relations with staff and colleagues. Thus, training the willing leaders in mindfulness would be another project proposal. Moreover, the
organization can provide various mindfulness-based strategies and self-care resources to staff in the benefits package, e.g., discounted, or free access to mindfulness-based courses.

In a nutshell, the high prevalence of compassion fatigue, stress, and compassion fatigue needs to be mitigated by adequately providing self-care resources to the psychiatric healthcare staff. Mindfulness-based strategies have been supported by evidence to reduce stress and burnout and increase empathy levels in HCPs. Therefore, providing mindfulness-based strategies would be an ethically and empirically proven tool to promote self-care among the psychiatric staff.
References


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https://www.who.int/occupational_health/topics/stressatwp/en/

Appendices

Appendix A

Statement of Determination

Doctor of Nursing Practice
Statement of Non-Research Determination (SOD) Form

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

General Information

Last Name: Bajwa
First Name: Harkirat
CWIID Number: 20602775
Semester/Year: Semester 6/2022
Course Name & Number: NURS 749B Practicum: NP Qualifying Project: Prospectus Development

Chairperson Name: Dr. Trinette Radasa
Advisor Name: Dr. Trinette Radasa
Second Reader Name: Dr. Jo Loomis

Project Description

1. Title of Project: “Implementing a mindfulness-based toolkit to support self-care among psychiatric healthcare staff.”

2. Brief Description of Project

Nearly 50% of the physicians and 25% of the nurses in the United States experience burnout (Reith, 2018). Causes of CF and burnout are prolonged exposure to the clients’ trauma and stress, long working hours, and care burden in healthcare professionals. However, due to additional and innate stressors like violent and unpredictable patients, mental health professionals are at increased risk of burnout (Maslach & Leiter, 2016).

Burnout and compassion fatigue leads to the feeling of hopelessness and decreased efficacy and productivity on the job. It directly impacts the quality of care delivered to the clients, adverse patient outcomes, patient safety, increased practice errors, and relationship conflicts among professionals.
(Mangoulia et al., 2015; Nantsunawat et al., 2016; Suleiman-Martos et al., 2020; Tawfik et al., 2019; Teng et al., 2010). The physical and mental health of providers is hugely impacted by burnout (Salvagioni et al., 2017). The high turnover rate and increased sick calls due to burnout increase the healthcare cost of recruiting and retaining employees. Stress can contribute up to 40% of staff turnover and 80% of work-related injuries (Sarafis et al., 2016).

Many studies suggest that Mindfulness-Based Stress Reduction (MBSR), effectively reduces CF, burnout, and stress and improves empathy and compassion in mental health care providers (Ameli et al., 2020; Lamothe et al., 2015; Suleiman-Martos, 2020). This project aims to implement Mindfulness-Based toolkit to promote self-care among for psychiatric healthcare professionals to prevent CF, burnout, and stress.

3. **AIM Statement: What are you trying to accomplish?**
This project aims to develop, implement, and evaluate a mindfulness-based self-care toolkit for psychiatric healthcare professionals by June 2023.

4. **Brief Description of Intervention** (150 words):
The psychiatric healthcare professional’s knowledge and use of mindfulness strategies for self-care will be assessed via a questioner. A one-hour session about different mindful strategies will be conducted. Also, an easy-to-follow toolkit about mindful based self-care strategies will be posted in units and staff lounges. Staff will be instructed to practice mindfulness-based stress reduction strategies for a period of three months. A posttest will be implemented to assess the staff’s knowledge and use of mindfulness for self-care. Also, a survey will be collected to assess if the toolkit was easy to follow.

5. **How will this intervention be implemented?**
Intervention will be implemented at an acute psychiatric hospital in Fremont California. The population of focus in intervention will be psychiatric healthcare staff (nurses, mental health technicians, psychiatrists, case managers) working at the psychiatric hospital. Meetings with CEO/director of nursing would be conducted to discuss the need of the project. Participants will be informed in a monthly nursing
DNP Statement of Determination
Evidence-Based Change of Practice Project Checklist*

*The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:

"Implementing a mindfulness-based toolkit to support self-care among psychiatric healthcare staff."

<table>
<thead>
<tr>
<th>Mark an “X” under “Yes” or “No” for each of the following statements:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The specific aim is to improve performance on a specific service or program and is a part of usual care. All participants will receive standard of care.</td>
<td>x</td>
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</tr>
<tr>
<td>The project is not designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control. The project does not follow a protocol that overrides clinical decision-making.</td>
<td>x</td>
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</tr>
<tr>
<td>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.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project has no funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>The agency or clinical practice unit agrees that this is a 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 colleagues, students and/or patients.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: &quot;This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.&quot;</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
**Answer Key:**

- If the answer to **all** of these items is “Yes”, the project can be considered an evidence-based activity that does **not** meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files.
- If the answer to **any** of these questions is “No”, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.*

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: [http://answers.hhs.gov/ohrp/categories/1569](http://answers.hhs.gov/ohrp/categories/1569)
DNP Statement of Determination
Evidence-Based Change of Practice Project Checklist Outcome
The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). **Student may proceed with implementation.**

☐ This project involves research with human subjects and **must be submitted for IRB approval before project activity can commence.**

Comments:

**Student Last Name:** Bajwa  
**Student First Name:** Harkirat

**Student Signature:**  
**Date:**

**Chairperson Name:**  
**Chairperson Signature:**  
**Date:**

**Second Reader Name:**  
**Second Reader Signature:**  
**Date:**

**DNP SOD Review Committee Member Name:**

**DNP SOD Review Committee Member Signature:**  
**Date:**
Appendix B

Letter of Support from agency

9/01/2022

To Whom this may Concern,

This is a letter of support for Harkirat Kaur Bajwa to implement her DNP Comprehensive Project “Implementing a mindfulness-based toolkit to promote self-care among psychiatric healthcare staff” at Fremont Hospital.

[Signature]

Jessica Cedillo MSN, BSN, RN
Interim Director of Nursing
Jessica.Cedillo@uhscine.com
510-510-818-6322

Dedicated to Hope, Healing and Recovery
## Appendix C

### Evidence Evaluation Table

<table>
<thead>
<tr>
<th>Purpose of Article or Review</th>
<th>Design / Method / Conceptual Framework</th>
<th>Sample / Setting</th>
<th>Major Variables Studied (and their Definitions)</th>
<th>Measurement of Major Variables</th>
<th>Data Analysis</th>
<th>Study Findings</th>
<th>Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Randomized clinical trial (RTC) to evaluate a brief mindfulness-based program effect on stress in healthcare professional (HCPs).</td>
<td>TC R</td>
<td>82 HCPs from the National Institute of Health (NIH), Maryland, were randomly assigned to a brief mindfulness program (five sessions) and a control group.</td>
<td>Primary: Stress levels Secondary: Anxiety levels, burnout, mindfulness state, and knowledge of mindfulness-based self-care</td>
<td>Stress: Perceived Stress Scale. Burnout by using Maslach burnout inventory (2 items only: EE and depersonalization). Anxiety: Visual Analog Scale. For state mindfulness: The Mindful Attention Awareness Scale Trait (MAAS-T) and State (MAAS-S).</td>
<td>Fisher exact test or $\chi^2$: statistical analysis of categorical data. two-sample t-tests: analyzed continuous data between groups. 95% CIs were used to report the effect size.</td>
<td>Reduced score of stress, not reduced scores of burnouts increased mindfulness- not immediately but after 13 weeks.</td>
<td>The study is high-quality with level I evidence on the JHEBP appraisal tool. Weakness: sample size was predominately women from an educated background; might impact generalizability. Strengths: showed feasibility of a brief mindfulness program. Good number of participants follow up.</td>
</tr>
</tbody>
</table>


EE- emotional exhaustion.
<table>
<thead>
<tr>
<th>Purpose of Article or Review</th>
<th>Design / Method / Conceptual Framework</th>
<th>Sample / Setting</th>
<th>Major Variables Studied (and their Definitions)</th>
<th>Measurement of Major Variables</th>
<th>Data Analysis</th>
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<th>Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) / APA Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>An efficacy study to evaluate mindfulness-based cognitive therapy's (MBCT, an eight-week program) effect on burnout in mental healthcare professional (MHPs).</td>
<td>The sample included 86 allied mental health professionals working with Northwest National Health Services (NHS).</td>
<td>Burnout: characterized by emotional exhaustion, depersonalization, and personal accomplishment. State mindfulness: by Freiburg Mindfulness Inventory Correlations of mindfulness with burnout was also measured.</td>
<td>Burnout by using Maslach burnout inventory. State mindfulness: by Freiburg Mindfulness Inventory Correlations of mindfulness with burnout was also measured by correlation coefficient.</td>
<td>One-way analysis of variance (ANOVA)</td>
<td>Statistically significant reduced burnout and increased mindfulness in MHPs; the effect was retained after six months. Statistically significant negative correlation between mindfulness and burnout.</td>
<td>Level II; high quality</td>
<td></td>
</tr>
<tr>
<td>Efficacy study; no control group.</td>
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</tbody>
</table>

An efficacy study to evaluate mindfulness-based cognitive therapy's (MBCT, an eight-week program) effect on burnout in mental healthcare professional (MHPs).
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</tr>
</thead>
<tbody>
<tr>
<td>To evaluate the effect of mindfulness-based yoga on stress, burnout healthcare professionals (HCPs) compared to control group.</td>
<td>Randomized controlled trial; single blinded</td>
<td>80 healthcare workers (nursing assistants, therapists, nurses, physicians, and social workers) working in direct patient care in a hospital in the southwestern United States.</td>
<td>Major variables were Stress and burnout (characterized by emotional exhaustion, depersonalization, and personal accomplishment) Other variables were Sleep quality; serenity; mindfulness; salivary cortisol and blood pressure.</td>
<td>Sleep quality by Global Sleep Quality; serenity by Brief Serenity Scale; Mindfulness by Mindful Attention Awareness Scale. Biomarkers of salivary cortisol and Blood pressure measurement. Maslach burnout inventory for burnout Perceived stress scale: Stress</td>
<td>Done by Descriptive statistics one-way analysis of variance (ANOVA) for comparison in between intervention and control group. ANOVA and Wilcoxon rank-sum test to compare salivary cortisol between two groups.</td>
<td>The mindfulness-based yoga results in statistically significant lower levels of burnout and stress, sleep quality, serenity, and mindfulness, compared to the control group (p&lt;.01); no significant changes in cortisol levels and B.P measurements were noted.</td>
<td>The study is high-quality with level I evidence on the JHEBP appraisal tool. Weakness: All tools are self-reported Strengths: Good number of follow up participant; high level RTC Worth to Practice: Yes; proved high quality evidence to use mindfulness yoga to reduce stress and burnout in HCPs,</td>
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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>To evaluate the effect of mindfulness-based project on compassion of Nursing staff.</td>
<td>Qualitative descriptive design</td>
<td>9 nurses and certified nursing assistants (CNAs) working at University of Colorado, Anschutz Medical Campus, Colorado.</td>
<td>N/A</td>
<td>Use of memos, indicative approach to discover themes from descriptive data.</td>
<td>Thematic description of data</td>
<td>Minfulness-based self-care intervention increase empathy and compassion in nursing staff and in turn promote safe unit culture.</td>
<td>Level III; high quality evidence. The study provides high-quality evidence for incorporating mindfulness based interventions into health care environments. Small sample size was a drawback. Prompts further research at large levels.</td>
</tr>
</tbody>
</table>

| Purpose of Article or Review | Design / Method / Conceptual Framework | Sample / Setting | Major Variables Studied (and their Definitions) | Measurement of Major Variables | Data Analysis | Study Findings | Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /
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</thead>
<tbody>
<tr>
<td>To evaluate the feasibility of 3-minute mindfulness intervention (3MBS) on CF, BO, STS, and CS in acute care nurses.</td>
<td>A quasi-experimental. Single group pre/posttest design.</td>
<td>30 RNs working in acute/critical care in 5 New York City area hospitals. Participants were members of the American Association of Critical-Care Nurses (AACN).</td>
<td>BO: burnout CS: compassion satisfaction: STS: secondary traumatic stress</td>
<td>The Professional Quality of Life Test (ProQOL): for 3 aspects of CF: CS, BO, and STS.</td>
<td>Descriptive statistics Paired sample t test.</td>
<td>The results of this study concluded that nurses breathing mindfully for 3 minutes over a period of 4 weeks experience reduced CF.</td>
<td>The study is high-quality with level II evidence on the JHEBP appraisal tool. Weakness: sample size was predominately women from an educated background; might impact generalizability. Strengths: showed feasibility of a brief mindfulness program. Good number of participants follow up.</td>
</tr>
</tbody>
</table>


CF-Compassion fatigue; BO- Burnout; CS- compassion satisfaction. STS: secondary traumatic stress.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>To evaluate and synthesize the effect of mindfulness-based interventions on stress and self-compassion of HCPs.</td>
<td>A systemic review and meta synthesis.</td>
<td>PRISMA guidelines for systemic reviews A total of nine articles for systematic review and six articles included for meta-analysis.</td>
<td>Stress, Self-compassion: being aware of one’s own suffering and methods to alleviate them, and mindfulness (being present in the moment).</td>
<td>For metanalysis of outcome variables: inverse variance statistical method was used with a random effects model.</td>
<td>Various tools like random effect model: to assess effect size; 95% confidence intervals, standardized mean differences; I² statistic (to assess heterogeneity) of results.</td>
<td>Various mindfulness strategies reduced stress and increased mindfulness in HCPs. But there is paucity in literature about effects of mindfulness on compassion fatigue. However, studies suggest practicing mindfulness increase self-compassion. Self-compassion has been shown to increase compassion towards others.</td>
<td>Level II; high quality evidence Weakness: Less studies on effect of mindfulness on all three variables in together. A small sample size in studies is another limitation. Worth to practice: provide high quality meta-analysis on use of mindfulness in HCPs.</td>
</tr>
<tr>
<td>Purpose of Article or Review</td>
<td>Design / Method / Conceptual Framework</td>
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</tr>
<tr>
<td>To determine the effect of a 4-hour session of mindfulness teaching on burnout, stress levels and state of mindfulness of nurses.</td>
<td>A quasi experimental; pretest posttest design.</td>
<td>52 nurses from a Midwestern urban academic institute and its affiliated community hospitals</td>
<td>Burnout; characterized by emotional exhaustion, depersonalization, and personal accomplishment.</td>
<td>Burnout: Maslach burnout inventory Stress: Perceived Stress Scale, State of mindfulness: Cognitive and Affective Mindfulness Scale</td>
<td>Changes in participants’ perceptions of burnout, stress, and mindfulness was tested by sing t tests Standard descriptive statistics was used to analyze demographic data.</td>
<td>A four-hour mindfulness workshop significantly reduced stress, burnout in nurses. Retained the results after 6 months with increase in mindfulness.</td>
<td>Level II; high quality evidence</td>
</tr>
</tbody>
</table>

**Definition of abbreviations**
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>To synthesize evidence about effect of mindfulness-based strategies in Nurses’ burnout.</td>
<td>A systematic review and meta-analysis</td>
<td>17 randomized clinical trials and quasi experimental studies were chosen as per PRISMA guidelines to determine effect of mindfulness on nurses ‘burnout.</td>
<td>Burnout: characterized by emotional exhaustion, depersonalization, and personal accomplishment. Use of mindfulness for self-care.</td>
<td>Burnout by using Maslach burnout inventory.</td>
<td>For data abstraction: Manual coding; Cohen’s kappa and intraclass correlation Coefficient. Descriptive statistics for systemic review. I² index for meta-analysis.</td>
<td>Mindfulness training resulted in lower emotional exhaustion and depersonalization and increasing personal accomplishment (the three components of burnout).</td>
<td>Level II; high quality evidence provided by systematic review for use of mindfulness for combating burnout in healthcare professionals. Weakness: few RTCs were available; so quasi experimental studies were included. Recommendations: More high-quality studies needed.</td>
</tr>
</tbody>
</table>

| Purpose of Article or Review | Design / Method / Conceptual Framework | Sample / Setting | Major Variables Studied (and their Definitions) | Measurement of Major Variables | Data Analysis | Study Findings | Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) / APA Reference |
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### Purpose of Article or Review
A meta synthesis of qualitative studies to determine the effects and experiences of mindfulness training on nurses.

### Design / Method / Conceptual Framework
A qualitative meta synthesis

### Sample / Setting
Three mixed method studies and two qualitative studies.

### Major Variables Studied (and their Definitions)
- **Stress conceptualization:** nurses’ perception of stress.
- **Valued aspects of mindfulness training**
- **Self-care awareness**
- **Challenges of implementing mindfulness training.**

### Measurement of Major Variables
- **Thematic analysis:** Following themes were discovered:
  1. Stress conceptualization and management;
  2. Valued aspects of mindfulness training;
  3. Self-care awareness and strategies;
  4. Challenges of mindfulness training.

### Data Analysis
Nurses depicted that mindfulness training helped them to reevaluate the way they looked at the stress and to learn positive coping skills to deal with stress, like pausing for a moment and taking deep breaths instead of crying. They also became more confident, calmer, and emotionally stable, and more focused on patients. Nurses also felt valued that organizations take efforts to alleviate stress. Also, nurses found the value of self-care.

### Study Findings
Level III; high/good quality evidence

### Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s)
Weakness: Qualitative studies and voluntary participation of subjects might have biased the results. Time commitment made mindfulness interventions less feasible in healthcare environment.

Worth to practice: Provides nurse’s point of view for mindfulness training and effects on stress, depicts nurses feel valued if organization validate their stress.
Appendix D

Diffusion of Innovations Theory Model

Source: Everett Rogers, *Diffusion of Innovations*
Appendix E

Transactional Model of Stress and Coping

Stressor

Relevant
Irrelevant

Harmful
Gainful

Primary appraisal

Available resources:
- Positive coping
- Expert advice
- Social support

Situation demands
- Perceived threat
- Uncertainty
- Risk

More than situational demands:
Positive stress response

Less stress and positive coping mechanisms

More than available resources:
Negative stress response

Secondary appraisal
Appendix F

Stakeholder Analysis (Power vs. Interest grid)

<table>
<thead>
<tr>
<th>Power</th>
<th>Keep Satisfied High Power, Low Interest</th>
<th>Manage Closely High Power, High Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>• Executives (CEO)</td>
<td>• Nurse managers</td>
</tr>
<tr>
<td></td>
<td>• Population under study (nurses,</td>
<td>• Nurse educators</td>
</tr>
<tr>
<td></td>
<td>mental health technicians, case</td>
<td>• Director of Nursing</td>
</tr>
<tr>
<td></td>
<td>managers, psychiatrists)</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hospital IT department</td>
<td>• Hospital staff</td>
</tr>
<tr>
<td></td>
<td>• Hospital staff</td>
<td>• Family, Friends</td>
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</table>
## Gap Analysis

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future state/ best practice recommendation</th>
<th>Gap</th>
<th>Actions to close gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk of burnout (BO), stress, and compassion fatigue (CF) in MHPs</td>
<td>Provision/ promotion of appropriate self-care resources to staff in psychiatric hospitals</td>
<td>Ineffective use of mindfulness-based strategies</td>
<td>Create and implement mindfulness-based self-care toolkit for staff use</td>
</tr>
<tr>
<td>No provision of self-care tools to prevent BO, stress, and CF</td>
<td>Mindfulness-based strategies effectively reduce BO, CF, and stress</td>
<td>Lack of knowledge about mindfulness in staff</td>
<td></td>
</tr>
</tbody>
</table>

- High risk of burnout (BO), stress, and compassion fatigue (CF) in MHPs
- No provision of self-care tools to prevent BO, stress, and CF

- Provision/ promotion of appropriate self-care resources to staff in psychiatric hospitals
- Mindfulness-based strategies effectively reduce BO, CF, and stress

- Ineffective use of mindfulness-based strategies
- Lack of knowledge about mindfulness in staff

- Create and implement mindfulness-based self-care toolkit for staff use
Appendix H

Work Breakdown Structure

Implementing a mindfulness-based self-care toolkit for psychiatric staff

Planning the project 1.1

- Presentation about need of project to CEO 1.1.1
- Initiate an affiliation agreement between SONPH and clinical site 1.1.2
- Deliverable: Affiliation agreement done 1.1.3
- Get a letter of support from the site 1.1.4

Designing the toolkit 1.2

- Designing posters about Mindfulness-based strategies 1.2.1
- Designing badge buddies 1.2.2
- Design flyers 1.2.3
- Develop PowerPoints 1.2.4
- Designing the training manual 1.2.5

Implementation of Toolkit 1.3

- Collect pre-assessment surveys about mindfulness-based self-care knowledge 1.3.1
- Education session to staff about mindfulness and use of toolkit 1.3.2
- Distribute toolkit materials to staff 1.3.3
- Display posters in the units/staff lounge 1.3.4

Evaluation of toolkit 1.4

- Collect staff surveys about mindfulness-based self-care knowledge 1.4.1
- Compare staff’s pre and post knowledge about mindfulness-based strategies 1.4.2
- Collect surveys and feedback about toolkit use 1.4.3
- Incorporate changes in toolkit based on feedback 1.4.4
Appendix I

GANTT Chart

<table>
<thead>
<tr>
<th>Phases and Steps</th>
<th>2022</th>
<th>2023</th>
<th>Year</th>
<th>Status</th>
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<tr>
<td><strong>Planning Phase</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Presentation of project to CEO</td>
<td>[X]</td>
<td>[X]</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>1.2 Initiate an affiliation agreement</td>
<td>[X]</td>
<td>[X]</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>1.3 Send a letter of support and affiliation agreement</td>
<td></td>
<td></td>
<td>Original</td>
<td></td>
</tr>
<tr>
<td>1.4 Literature Review</td>
<td>[X]</td>
<td>[X]</td>
<td>Completed</td>
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<tr>
<td><strong>Designing the Toolkit</strong></td>
<td></td>
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<tr>
<td>2.1 Designing the posters</td>
<td>[X]</td>
<td></td>
<td>Pending</td>
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</tr>
<tr>
<td>2.2 Designing the flyers, Braille buddies</td>
<td>[X]</td>
<td></td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td>2.3 Design power points about workshop</td>
<td></td>
<td></td>
<td>Pending</td>
<td></td>
</tr>
<tr>
<td><strong>Implementation Phase</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Collect the assessment surveys</td>
<td></td>
<td></td>
<td>[X]</td>
<td>Pending</td>
</tr>
<tr>
<td>3.2 Education session to staff about toolkit and mindfulness</td>
<td></td>
<td></td>
<td>[X]</td>
<td>Pending</td>
</tr>
<tr>
<td>3.3 Distribute toolkits to staff</td>
<td></td>
<td></td>
<td>[X]</td>
<td>Pending</td>
</tr>
<tr>
<td>3.4 Display Posters in staff</td>
<td></td>
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<td></td>
<td>Pending</td>
</tr>
<tr>
<td>3.5 Meeting with staff Question/answer session</td>
<td></td>
<td></td>
<td></td>
<td>Pending</td>
</tr>
<tr>
<td><strong>Evaluation phase</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Collected post education staff surveys about mindfulness-based self care</td>
<td></td>
<td></td>
<td>[X]</td>
<td>Pending</td>
</tr>
<tr>
<td>4.2 Compare staffs pre and post intervention knowledge about mindfulness based strategies</td>
<td></td>
<td></td>
<td></td>
<td>Pending</td>
</tr>
<tr>
<td>4.3 Collected surveys from feedback about toolkit</td>
<td></td>
<td></td>
<td></td>
<td>Pending</td>
</tr>
<tr>
<td>4.4 Incorporate changes in toolkit based on feedback</td>
<td></td>
<td></td>
<td></td>
<td>Pending</td>
</tr>
<tr>
<td>4.5 Meeting with critical stakeholders about project customs and possible continuation of project</td>
<td></td>
<td></td>
<td></td>
<td>Pending</td>
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<tr>
<td>4.6</td>
<td></td>
<td></td>
<td></td>
<td>Pending</td>
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</table>

Implementing mindfulness-based self care toolkit GANTT Chart
# Appendix J

## SWOT Analysis

<table>
<thead>
<tr>
<th></th>
<th>Favorable/Helpful</th>
<th>Unfavorable/Harmful</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal (attributes of the organization)</strong></td>
<td><strong>Strengths</strong>&lt;br&gt;• Easy to use toolkit  &lt;br&gt;• Readily accessible to staff  &lt;br&gt;• Low-cost toolkit  &lt;br&gt;• Less time commitment as compared to the mindfulness-based stress reduction (MBSR) program</td>
<td><strong>Weaknesses</strong>&lt;br&gt;• Success depends on staff’s use of the toolkit  &lt;br&gt;• Lack of staff’s interest  &lt;br&gt;• Lack of motivation from management</td>
</tr>
<tr>
<td></td>
<td><strong>Opportunities</strong>&lt;br&gt;• The culture of promoting self-care among health care organizations; mindfulness is widely accepted form of self-care.  &lt;br&gt;• Mindfulness practice have shown to increase staff retention and improved patient safety.</td>
<td><strong>Threats</strong>&lt;br&gt;• Use of online apps available for practicing mindfulness by staff  &lt;br&gt;• Other available forms of self-care resources use by staff.  &lt;br&gt;• Lack of funding for continuation of project.</td>
</tr>
</tbody>
</table>
# Appendix K

## Proposed Budget

<table>
<thead>
<tr>
<th>Category</th>
<th>Expenses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Material cost</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Time to design the toolkit (30 hours)</td>
<td>$1950 ($65/hour)</td>
<td>$2380</td>
</tr>
<tr>
<td>- Printing out handouts</td>
<td>$ 30 (15 cent/handout)</td>
<td></td>
</tr>
<tr>
<td>- Posters</td>
<td>Posters: $ 100 ($20/Poster)</td>
<td></td>
</tr>
<tr>
<td>- Custom badge holders</td>
<td>Custom badge holders: $300</td>
<td></td>
</tr>
<tr>
<td><strong>Education Session</strong></td>
<td></td>
<td>$3920</td>
</tr>
</tbody>
</table>
|  1 hour + 30 mins/month (3 months) = 2.5 hours | Nurse Educator $ 68 x 2.5 hours = $170  
|                            | Staff: 30 (50x2.5) = 3750                    |        |
| **Material cost + Education sessions** |                                               | $6300  |
## Appendix L

### Communication Plan Matrix

<table>
<thead>
<tr>
<th>Communication</th>
<th>Who</th>
<th>Frequency</th>
<th>Goal</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stakeholder’s meetings for project planning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stakeholder’s Meeting</td>
<td>CEO</td>
<td>Once</td>
<td>A presentation about project</td>
<td>Face to Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Discussion about needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>paperwork to implement the project</td>
<td></td>
</tr>
<tr>
<td>Stakeholder’s Meeting</td>
<td>DON, CEO, Nurse educator</td>
<td>Once</td>
<td>Getting the letter of support signed</td>
<td>Face to Face</td>
</tr>
<tr>
<td>Stakeholder’s Meeting</td>
<td>Unit Staff</td>
<td>Once</td>
<td>To touch base with staff/</td>
<td>Face to Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>charge nurses about the project</td>
<td></td>
</tr>
<tr>
<td>Toolkit training meeting</td>
<td>Staff</td>
<td>Once</td>
<td>Training on mindfulness</td>
<td>Face to face /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>strategies and use of toolkit</td>
<td>Zoom</td>
</tr>
<tr>
<td>Toolkit training/ Question</td>
<td>Staff</td>
<td>Monthly</td>
<td>To have a question/answer</td>
<td>Face to face/</td>
</tr>
<tr>
<td>Answer session</td>
<td></td>
<td></td>
<td>session/ any feedback</td>
<td>Zoom</td>
</tr>
<tr>
<td>Evaluation meeting</td>
<td>Staff</td>
<td>Once</td>
<td>Feedback on toolkit</td>
<td>Face to face /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Collect Post surveys</td>
<td>Zoom</td>
</tr>
<tr>
<td>Stakeholder’s meeting</td>
<td>CEO+DON+ nurse educator</td>
<td>Once</td>
<td>Discussion of toolkit’s</td>
<td>Face to face /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>evaluation/ plan to continue</td>
<td>Zoom</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>implementation</td>
<td></td>
</tr>
</tbody>
</table>