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A Wellness Initiative: Mindfulness Training for Unlicensed Assistive Personnel to Promote Self-Care and Enhanced Well-Being

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GW Nursing

DOCTOR OF NURSING PRACTICE PROGRAM

A DNP PROJECT

TITLE: A Wellness Initiative: Mindfulness Training for Unlicensed Assistive Personnel to Promote Self-Care and Enhanced Well-Being

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Abstract

Background: Burnout leads to decreased staff engagement, productivity, and high attrition rates. The nursing staff most impacted are Unlicensed Assistive Personnel (UAP); therefore, to combat burnout, resilience is to be cultivated. Resilience begins with *self-care,* which is nurturing the self: mind, body, and soul to safeguard *well-being*.

Objectives: This project provided *mindfulness* training as a wellness initiative to promote *self-care* skills and enhance *well-being* among the UAP within a healthcare facility.

Methods: This project followed an evidenced-based quality improvement practice framework (Mindful Self-Care Scale-Brief and IHI- Well-Being Assessment Survey) and used a pre-post-test design to compare *self-care* and *well-being* after a *mindfulness* training program.

Results: Nine female UAPs participated in the intervention; seven completed the pre- and post-Mindful Self-Care Scale-B (MSCS-B) and the IHI- Well-Being Assessment Survey**.** The MSCS-B pre and post-intervention mean scores were favorable for *self-care*: pre-intervention means = 83.25 (SD =17.351); post-intervention means = 88.57 (SD = 7.525), and paired sample t-test showed an increase in *self-care* behaviors and proved statistically significant with a p-value < 0.1. The IHI-Well-being Assessment showed no significance statistically.

Conclusion: This intervention suggests *mindfulness* training promotes *self-care* and may enhance *well-being.* Self-care benefits are essential to the UAP to build resilience and prevent burnout. Healthcare organizations must embrace *mindfulness t*raining as it lends itself to a shift in culture: Better patient interaction, quality of care, and communication,

as well as a decreased attrition rate. This step is a start for continued study of *mindfulness* in the UAP.

K***eywords*:** Mindfulness, Self-care, Well-being, Burnout, MBSR, UAP

A Wellness Initiative: Mindfulness Training for Unlicensed Assistive Personnel to Promote Self-care and Enhanced Well-being

Introduction

Mindfulness is the awareness of paying attention on purpose by being present in the moment without judgment of the experience (Hoover et al., 2020). Mindfulness is the pre-conceptual awareness that involves an attitude of acceptance, openness, and nonreactivity towards ongoing thoughts or feelings that appear in our consciousness without trying to alter them (Gaspar, Martinho, & Lima, 2018). Mindfulness is the awareness and acceptance of an emotional experience (Armstrong & Rimes, 2015).

"To be mindful comes from the Buddhist term sait, which means awareness, and samprajanya means clear comprehension." (Grecucci et al., 2015, p. 1). Vago and Zeidan (2016) referenced the classic Buddhist perspective that the stillness and stability of the mind provide liberation from harmful emotions and cognitive experiences.

Mindfulness is taught to cultivate acceptance and nonjudgmental attitudes toward the Self by allowing recognition of thoughts and feelings through mindfulness-based interventions (Armstrong & Rimes, 2015). Mindfulness interventions enhance well-being by alleviating stress and strengthening psychological function (Hewett et al., 2011). Mindfulness meditation, a *mindfulness* skill, has become a widely used psychological stress-reduction technique (Grecucci et al., 2015). Mindfulness meditation has been shown to remedy clinical problems such as depression, stress, and anxiety (Tan et al., 2014). Westphal et al. (2021) hypothesized that *mindfulness* promotes health by safeguarding against the negative impact of stress. Black and Slavich (2016) described *mindfulness* meditation as a systematic framework and process to

cultivate *mindfulness* in daily life through intentional and deliberate practice. Teaching individuals to integrate *mindfulness* into their lives can contribute to the abatement of psychological and physical suffering, additionally promoting *well-being* (Lacaille et al., 2018).

Background and Significance

Burnout is routinely defined as a syndrome consistent with emotional exhaustion, depersonalization, and reduction in personal accomplishments (Rees et al., 2019). Burnout results from prolonged work-related perceived stress and anxiety, which can result in losing idealism and energy (Morrison et al., 2017). Harolds (2019) described burnout as a greater energy output for the individual. Khamisa et al.(2016) described critical elements of burnout as job dissatisfaction and decreased physical and mental health. Healthcare professionals are experiencing burnout at an alarming rate, but the nursing staff is most impacted (Thieman, 2018). Burnout increases staff turnover, limits patients' positive experiences, decreases staff engagement and productivity, and increases the risk of workplace incidents (Thieman, 2018). According to Boehm et al. (2017), a disturbance in the care team's relationships can lead to a breakdown in communication, resulting in quality and safety events while costing hospitals approximately $8.1 million due to turnover. (Rushton et al., 2015). Rees et al. (2019) avowed that individuals with well-developed psychological capital, such as self-efficacy and resilience, can cope with overwhelming situations. Therefore, building resilience is a possible way to allay burnout.

Kelly (2011) stated that "resiliency, or the ability to bounce back from difficulty, is vital to assuage burnout (p.620). Rushton et al. (2015) stated that resilience helps with alleviating burnout and defines it as the "ability to adapted coping strategies to minimize distress." (p. 413).

Attestation of the literature indicated that resilience could help decrease stress and burnout. An essential characteristic of resilience is how an individual responds to stress, an internal energy that allows an individual to persist (Grafton et al., 2010; Yu et al., 2019). Accordingly, resilience should be viewed and acknowledged as a dynamic and fluid process requiring continuous nurturing and commitment, including adaptability and flexibility (Henshall et al., 2020).

Self-care is defined as caring for oneself without medical or professional assistance; it is the preservation of the self (Godfrey et al., 2011). To prevent burnout and cultivate resilience, the maintenance of the self is imperative. The epitome of *self-care* is to immerse oneself in activities that promote *well-being* in the mind, body, and spirit (Crane & Ward, 2016).

Well-being is recognized as a phenomenon encompassing physical, mental, and emotional health, influenced by the individual and their environment (Brigham et al., 2018). Jarden and Roache (2023) characterized *well-being* as having a combination of elements within and across classifications of emotion, behavior, cognition, and relationships. "Well-being is understood as how people feel and function on a personal and social level, and how they evaluate their lives as a whole." (Michaelson, Mahony, & Schifferes, 2012, p.6). All healthcare professionals should be concerned about their *well-being*: preventing burnout and partaking in *self-care* is furthermore significant for the Unlicensed Assistive Personnel (UAP), who provides approximately 80% direct care in long-term care (LTC) and interacts with residents three times longer than nurses and is susceptible to job stressors (Kim et al., 2020).

Unlicensed Assistive Personnel

Grover and Fritz (2022) indicated that recent nursing shortages, complex patient care management, and cost containment challenges have contributed to the increase in UAP.

Individuals other than nurses who perform various clinical and non-clinical jobs that augment nursing care are referred to Unlicensed assistive personnel (Scott et al., 2020).

The UAP is categorized as certified nursing assistants (CNAs), nurse's aides, nurse technicians, medical assistants, clinical technicians, and patient care technicians who provide direct and indirect care activities under the supervision of a registered nurse (More & Parsons, 2020; Scott et al.,2020). UAP serves at many levels and undertakes technical skills depending on their experience and care delivery area (Gent, Proulx, & Seidl, 2014). The roles of UAP are broad but include the performance of personal hygiene activities, gathering, evaluating, recording, and reporting patients' physiological information, and maintenance of patient care areas and equipment (Jenkins & Joyner, 2013). It is acknowledged that the increasing gap in the developing role of the UAP and the lack of standardized and applicable training for the job puts UAP at the bottom of the professional care hierarchy with substantial responsibility (Band-Winterstein et al., 2019). The literature indicated that all healthcare organizations utilize UAP services.

Needs Assessment

A needs assessment of the Eastern healthcare facility was conducted to substantiate internal and external factors: strengths, weaknesses, opportunities, and threats (SWOT) within the facility (Appendix A). The predominant strengths were the mutual respect between leadership and staff, transformational leadership, a diverse workforce, and a Diversity, Equity, and Inclusion committee. The weaknesses included staffing shortage, increased workload, increased UAP attrition rate, and the omission of *self-care* education for the UAP. This weakness provided the facility with an excellent opportunity to implement a holistic training program such

as this project, which will aid the sustainability of staff and workforce recruitment efforts. Notable threats are staff burnout, an increased attrition rate, an increased risk for error, a decrease in quality care, and a lack of buy-in from the stakeholders for the training program due to time constraints.

This DNP project aimed to promote the practice of *self-care* and enhance *well-being* among the UAP as they are also under tremendous strain from an increased workload interfused with the prolonged burden of the COVID-19 pandemic while providing care short-staffed. There was an opportunity for the organization to implement a sustainability plan through a holistic approach to encourage this forgotten group's *well-being*, as the literature demonstrated that the focus has been primarily on nurses' health and *well-being.*

Unlicensed Assistive Personnel have also experienced perceived stress and anxiety related to burnout. Depaiva et al. (2017) state that burnout is a psychosocial problem of significance that affects all professionals because of stress in their work environment, which is highly prevalent in healthcare system professionals, consequently resulting in a negative impact on *well-being*: physical and mental health. Zeller and Levin (2013) reported that, as a result, workplace stress can interfere with nursing personnel’s ability to focus attentively, think clearly, and provide optimal patient care.

The role of the UAP is pivotal to the care team, as they provide direct patient care under the supervision of the registered nurse; thus, a facility stressed due to staffing shortage impacts the entire team. This phenomenon of a nursing shortage across the country invariably affects the *well-being* of the nursing staff. There was a good chance for progress in achieving healthcare team *well-being*, one part of the Quadruple Aim: better care, better health, and better workforce

experience (Sinsky et al., 2020). Well-being reminders can indicate that *mindfulness* or a *mindfulness*-based program must be an integral strategy to promote *self-care*.

The training for the UAP at the Eastern healthcare facility is a 2- or 3-day orientation and skill-based. Self-care behaviors are not taught, although, currently, with the demands of COVID-19, many are experiencing elevated stress levels. The health and *well-being* of the UAP influence the quality and safety of care provided, including the organizational system care (National Academy of Science, Engineering & Medicine (NASEM), 2021). All leaders should direct their attention to the health and *well-being* of the UAP, an integral part of the care team; safe and reasonable clinical workload and *well-being* are shared responsibilities with all leaders within the organizational structure (Sinsky et al.,2020).

The National Academy of Science, Engineering, and Medicine (2021) estimated the risk of burnout among nurses is 35-45%, but the percentage for the overall care staff is unknown; the literature does not address burnout in UAP. Knowledge of this statistic presents an opportunity to improve the *well-being* of UAP through *self-care* promotion. The Eastern healthcare facility has committed to UAP's *well-being* by recognizing the need to improve their workload and ascertain a solution.

Problem Statement

Nursing had a *well-being* problem before the COVID-19 pandemic, but now, the pandemic has imposed additional challenges and offers an opportunity to address healthcare workers' *well-being*. Across care settings, clinical staff are experiencing burnout at an alarming rate; consequently, the workplace holds mental, emotional, and physical challenges affecting the whole person (NASEM, 2021). The literature on burnout, stress, and *self-care* for UAP is minimal.

Most orientation training for newly hired nursing staff facilitates safe patient care (Peltokoski et al., 2016). Moreover, there is a tendency not to include *self-care* behaviors, although it is a fact that stress and anxiety can lead to burnout, which is an occupational syndrome driven by the work environment (Sinsky et al., 2020). Burnout will negatively impact healthcare workers and, eventually, the hospital system. Adopting the Institute for Healthcare Improvement (IHI) quadruple aim allows for a holistic approach to managing clinician *self-care* and building resilience, thereby improving work-life. Lubinska-Welch et al. (2016) stated that *self-care* is crucial for *well-being*. Richard and Shea (2011) described *self-care* as the ability to care for oneself and engage in necessary activities to achieve, maintain, or promote optimal health. Self-care is further defined by Cook-Cottone (2015) as "the daily process of being aware and attending to one's basic physiological and emotional need shaping a daily routine." Cook-Cottone and Guyker (2018, p. 3) delineated *mindful self-care* as an iterative process involving *mindful* awareness and assessment of one's internal needs and external demands and participation in intentional engagement in specific *self-care* practices to address needs and demands in a manner that serves their *well- being* and personal effectiveness.

A Mindfulness intervention, as demonstrated by the literature, is an appropriate intervention to utilize in the workplace to improve *self-care* and *well-being* to manage stress and burnout (Gaspar, Martinho, & Lima, 2018; Lacaille et al.,2018; Westphal et al., 2021).

Aim and Objectives

Purpose

The purpose of this project was to implement an evidence-based quality improvement *mindfulness* training program, as a wellness initiative for Unlicensed Assistive Personnel (UAP) to promote *self-care* behavior practices, through *mindfulness* to enhance *well-being* by utilizing practical coping skills to manage work demands and reduce the risk of burnout through the Palouse Mindfulness-Based Stress Reduction (MBSR) activities over eight weeks.

Aim

To promote *self-care* in the UAP through cultivating *mindfulness* into daily practice to enhance *well-being.*

Objectives

- Implement a *wellness* initiative: *Mindfulness* training for the Unlicensed Assistive Personnel for Fall 2023.
- Increase the Unlicensed Assistive Personnel *self-care* behaviors after applying a *wellness* initiative *mindfulness* training program.
- Increase the *well-being* of the Unlicensed Assistive Personnel after applying a *wellness* initiative *mindfulness* training program.
- Improve the Unlicensed Assistive Personnel's adoption of *mindfulness* daily practices after a *wellness* Initiative-Mindfulness training program.

Review of Literature

Evidence-Based Practice Question

Among Unlicensed Assistive Personnel (P), is *mindfulness* training (I) compared to standard practice (C) effective in promoting *self-care* and enhancing *well-being* (O) within 8 weeks?

Synthesis of the Evidence

Mindfulness is inherently the way of being, inhabiting our minds, bodies, and moment-to-moment experiences with intentions of openness and calm (Shapiro et al., 2008). Evidence shows that healthcare professionals are under tremendous stress due to higher patient acuity and demands (Penque, 2019). According to Knier et al. (2020), healthcare professionals have no meaningful coping mechanisms to sustain Well-being. Thus, a literature search was completed to answer the evidence-based practice (EBP) question to identify and synthesize the evidence supporting the utilization of Mindfulness-Based Stress Reduction (MBSR) in a clinical or everyday context as a group intervention characterized by the formal or informal teaching of meditation practices and yoga exercises (Conversano et al., 2020), or *mindfulness* training as a protective measure to improve self-compassion, emotions, thoughts, and reduced stress (Jimenez-Picon et al., 2021; & Penque, 2019). The literature search utilized PubMed, the Cumulative Index to Nursing Allied Health (CINAHL), and Clinical Keys. Keywords included burnout, perceived stress, stress, *mindfulnes*s, *self-care*, resilience, *well-being*, coping, *mindfulness* training, and MBSR with Boolean search methods, which included nursing, UAPs, and nursing staff. Inclusion criteria include English and international articles on *mindfulness*, MBSR, and *self-care* published within the last 15 years. There were 150 articles generated from the search, which were assessed for eligibility; 40 articles were reviewed and yielded 10 articles identified as appropriate (Appendix B) and were then appraised with the Johns Hopkins Nursing Evidence-Based Practice (JHNEP) Model (Dang & Dearholt, 2018).

The type of evidence examined were Randomized Control trials (RCTs), Systematic Reviews, Meta-Analysis, Mixed methods, and Quasi-Experimental, which support Mindfulness

or MBSR as interventions to manage a variety of outcomes such as perceived stress, anxiety, depression, burnout, resiliency, and *self-care.*

Mindful-Based Stress Reduction Intervention

Seven out of ten articles addressed MBSR as an intervention (Conversano et al., 2020; Daigle et al.,2018; Mackenzie et al.,2006; Manotas et al.,2014; Muir & Keim- Malpass, 2020; Sarazine et al., 2020; Spinelli et al.,2019). The findings indicated that using MBSR as a tool to enhance *mindfulness* shows moderate improvement during distress to promote coping and a reduction in adverse effects such as burnout, stress, and emotional exhaustion (Conversano et al., 2020; Mackenzie et al., 2006). MBSR intervention has shown lower levels of perceived stress; additionally, burnout and stress decreased with an increase in *mindfulnes*s (Mackenzie et al., 2006).

Length of MBSR

The length of the MBSR programs varied among the studies, from 4 weeks to the standard 8 weeks of MBSR intervention (Conversano et al., 2020; Mackenzie et al.,2006; Manotas et al.,2014; Sarazine et al., 2020). Adaptation from the standard 8-week MBSR intervention included 4-hour workshops and 4 weeks of 30-minute group sessions with homework from 10 minutes a day for 5 days via CDs or audio cassettes. Other interventions ranged from 2-hour sessions with 25 minutes of lecture on *mindfulness*; moreover, few were as long as 70 hours.

Mindfulness Intervention

Authors Burton et al. (2017), Conversano et al. (2020), Lomas et al. (2018), Querstret et al. (2018), and Spinelli., (2019) examined Mindful Based Interventions (MBIs), which indicated the potential to reduce stress, perceived stress ($p < 0.001$), depression ($p < 0.001$), and anxiety (p

< 0.001). Conversano et al. 2020; and Spinelli et al., 2019 queried MBSRs and MBIs. There were a variety of *mindfulness* interventions across the studies to aid with self-awareness, self-compassion, stress burnout, and anxiety. The *mindfulness* intervention included *mindfulness* breathing, yoga, meditation, and various other *mindfulness* activities. Conversano et al. (2020) state that *mindfulness* interventions were most effective on stress and job burnout.

All authors addressed burnout, linking stress as the etiology for this phenomenon in healthcare professionals due to the high demands of their work environment; however, only two (Mackenzie et al., 2006; Sarazine et al.,2020) directly measured burnout. Favorable results of using *mindfulness* by nurses included a perception of decreased stress and burnout and decreased emotional exhaustion (Sarazine et al., 2020).

Five of the articles focused on perceived stress and anxiety as outcomes to measure the usefulness of mindfulness training or MBSR programs (Burton et al., 2017; Lomas et al., 2018; Manotas et al., 2014; Querstret et al., 2018; Sarazine et al., 2020), which revealed promising results in reducing perceived stress and anxiety or increased *mindfulness* after the intervention.

For holistic consideration, *self-care*, self-compassion, and resilience were the focus of two articles (Conversano et al., 2020; Muir & Keim-Malpass, 2020), showing that *mindfulness* and MBSR interventions can improve these facets of individuals. Although the eight other articles addressed *well-being*, the concept was central to Daigle, Talbot, and French (2018) and Lomas et al. (2018) concerning their populations and outcomes with good evidence of *mindfulness* and MBSR interventions associated with more positive *well-being* and resilience outcomes showing a favorable impact.

The majority of the populations addressed in the articles were specific to healthcare professionals: Nurses, doctors, therapists, and midwives; others included social workers and

educators. Two articles focused on nurse aides (Mackenzie et al., 2006) and a non-clinical sample (Querstret et al.,2018) from the general population were administered online. All of the other studies were conducted in a clinical setting.

Each study utilized *mindfulness* skills, including *mindfulness* sitting, *mindfulness* breathing, meditation, *mindfulness* walking, and various other *mindfulness* activities; moreover, all showed improvement as an intervention.

Measurement tools and data collection instruments

The literature search yielded an abundance of measurement tools and data collection instruments and included 44 used among the studies. Few instruments were standard across the articles. The PSS scale was utilized in five studies (Burton et al., 2017; Manotas et al., 2014; Querstret et al., 2018; Sarazine et al., 2020; Spinelli et al., 2019). The MAAS was used twice (Burton et al., 2017; Conversano et al., 2020); other types of *mindfulnes*s or Awareness scales: FFMQ, AA, CAMS-R, and IMS (Burton et al., 2017; Conversano et al ., 2020; Manotas et al., 2013; Querstret et al., 2018; Sarazine et al., 2020; Spinelli et al. (2019). The BRS was used once by Spinelli et al. (2019). Three articles used the MBI (Mackenzie et al., 2006; Muir & Keim-Malpass., 2020; Sarazine et al., 2020). Varying other instruments and tools were utilized across the literature.

Across the majority of the studies, evidence shows that *mindfulness* training and MBSR programs can be effective interventions to promote *self-care*, build resilience and *well-being*. Gilmartin et al. (2017) stated that the dose and duration of *mindfulness* intervention ranged from 5 to 30 minutes regardless of in-person, virtual, home practice, or smartphone app-guided sessions. Monroe et al. (2021) noted the effectiveness of developing self-awareness and mindful practice to enhance a significant reflection of action by paying attention to thoughts, feelings,

bodily sensations, and judgment. Results have shown promise in nurses and other healthcare professionals; therefore, the UAP can benefit from *mindfulness* training as they endure the high stress and demands of the healthcare setting.

Evidence-Based Translation Model

Johns Hopkins Nursing Evidence-Based Practice Model

The evidence-based practice model selected to guide this DNP project implementation is the Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP). Permission to use the model was obtained by completing an online Copyright permission form. The JHNEBP model is endorsed by Newhouse et al. (2007) as practical for providing evidence-based practice leadership, setting expectations, establishing structure, building skills, and allocating human and material sources; additionally, this model can be integrated into graduate and undergraduate education, as evidence-based practice (EBP) is an essential element of professional nursing. Friesen et al. (2017) pointed out that nurses developed the model to incorporate the best evidence into nursing practice, nursing education, and clinical decision-making as an effective model to begin the evidence-based practice (EBP) process. Dang and Dearholt's (2018) discussion of the JHNEBP model included four paths to translate into practice based on the available evidence. The JHNEBP model consists of three headings: Practice question, Evidence, and Translation. Each heading follows procedural steps (Appendix C) that guide completing an EBP project (Dang & Dearholt, 2018). The following articulates the Implementation process for this project.

Practice questions

Step 1: Recruit an interprofessional team.

The interprofessional team consisted of the Project leader, the Director of clinical services, the care partner trainer, and the UAP shift scheduler.

Step 2: Define the problem.

It is a fact that stress and anxiety can lead to burnout, an occupational syndrome driven by the work environment; subsequently, burnout can have an adverse effect if *self-care* behaviors are not adapted to cope.

Step 3: Develop and refine the EBP question.

Among Unlicensed Assistive Personnel, is *mindfulness* training compared to standard practice effective in promoting *self-care* and enhancing *well-being* within 8 weeks?

Step 4: Identify stakeholders.

The key stakeholders are the UAP, the organization leadership, the Director of Clinical Services, the assistant director, the administrator, the UAP shift scheduler, and the care partner trainer.

Step 5: ***Determine responsibility for project leadership.***

The project leader's responsibilities included recruitment of the participants, managing data collection and analysis, data privacy and security, and all project processes.

Step 6: Schedule team meetings.

The team met biweekly on Thursday for 15 minutes to discuss the project, its progress, and any pertinent matters.

EVIDENCE

Step 7: Conduct internal and external search for evidence.

A systematic literature search was conducted through PubMed, CINHAL, and other sources to investigate research sources that examined *mindfulness* as an intervention to promote *self-care* and enhance Well-being with the help of a librarian who conducted a literature search covering 2003-2021. The investigator found ten articles that were of high quality using the Johns Hopkins Nursing Evidence-Based Appraisal tool.

Step 8: Appraise the level and quality of each piece of evidence.

Ten articles were appraised; four were Level I articles and of good quality; five were Level II articles, with two of good quality, two of low quality, and one of high quality. There was one high-quality Level III article.

Step 9: Summarize the individual evidence.

Evidence shows that *mindfulness* training is an effective intervention to promote self-care, build resilience, and enhance *well-being*. The evidence was persuasive and consistently demonstrated that *mindfulness* training was a practical method.

Step 11: Develop recommendations for change based on evidence synthesis.

Due to the limitations of the studies, the recommendation is for future studies to have diverse samples of participants to match the population, such as women, men, racially and ethnically, socioeconomically, and education level. In short, this intervention is applicable to many other populations.

TRANSLATION

Step 12: Determine fit, feasibility, and appropriateness of recommendation(s) for translation path.

This intervention was an excellent fit as a number of recent studies substantiated that nurses and physicians who participated in *mindfulness* classes showed a decrease in burnout (Goodman & Schorling, 2012), and thus was appropriate for the UAP as the intervention was geared to promote knowledge and skills of *self-care* through *mindfulness* training. Furthermore, the intervention's benefit will be an asset to the participants as Goodman and Schloring (2012), indicated that *mindfulness* is a practical technique to achieve *well-being*. The feasibility of this intervention is a benefit as the training is free and self-directed; additionally, there is no cost incurred to the healthcare facility. Moreover, the healthcare system may acquire a motivated workforce to ensure the quality of care and decrease attrition rates. Saks and Gruman (2015) argued that organizations can utilize *mindfulness* training for stress management and as part of employees' health and *wellness* programs.

Step 13: Create action plan

Appoint the project leader: The DNP student was the project leader.

***Change champion*s:** Eastern healthcare facility leadership, the care partner trainer, and the UAP shift scheduler.

Critical milestones and related tasks: Inform and educate the intervention participants and establish consent for participation in the training program. Gather participants' biographical data, *self-care*, and *well-being* data to develop a baseline for post-intervention comparison. Participants viewed a 3-minute *mindfulness* video facilitated by the project lead, followed by 8 weeks of self-directed *mindfulness* training. The Data from the outcome measures and surveys were aggregated to ascertain the usefulness of the Palouse MBSR course and the effectiveness of *mindfulness* training in promoting *self-care* behaviors and enhancing Well-being.

Schedules times to complete milestones: This *mindfulness* training intervention was expected to progress over eight weeks. The intervention was scheduled to start in October and end in December. Recruitment of eligible participants commenced in October. Before baseline data collection through REDCap, any UAP that agreed to participate in the project consented. The UAP engaged in guided *mindfulness* activities through the free online Palouse MBSR course through November and December.

Identify pre- and post-measures: The pre -and post-measures were the MSCS-B, the IHI - Well-being Assessment Survey, Demographics, and the Palouse MBSR Activity and Frequency Questionnaire.

Barriers to changes: Barriers to change can be a lack of interest in *mindfulness* training, participants forgetting to engage in *mindfulness* activities, having the feeling of time constraints to engage in activities, and the length of time for *mindfulness* training.

How changes will affect workflow: The participants engaged in the *mindfulness* training will be joyful and relaxed, which may have a positive effect on workflow. As a result of the training, their stress levels may decrease as they engage in *self-care* behaviors, allowing for calm and ease in their workday. Communication and interaction with other staff members would be more effective; additionally, participants would provide safe and quality patient care.

Confirm support and/ availability of funds to cover expenses: The facility leadership and stakeholders supported the initiative, achieved through feedback. This DNP project did not require significant funds to cover expenses.

Step 14: Secure support and resources to implement action plan.

The DNP project lead met with facility leaders to secure support for the project, and any resources needed to implement the plan were discussed.

Step 15: Implement action plan.

Project leader: Informed all to be involved and manage the *mindfulness* training process. UAP were sent weekly lesson plans to engage in guided *mindfulness* activity via the Palouse MBSR course. An appropriate data collection system. REDCap was used to store collected data.

Step 16: Evaluate outcomes

The project lead assessed the data to determine whether the *mindfulness* training intervention was successful and to conclude if the *mindfulness* training was effective in promoting *self-care* and enhancing *well-being.*

Step 17: Report outcome to stakeholders

The outcomes of the *mindfulness t*raining were shared with stakeholders for support in implementation and dissemination across the organization.

Step 18: Identify next steps

The following steps were based on the data showing that Mindfulness training is a valid and effective intervention to promote *self-care* and enhance *well-being*. The results were positive, and the following steps were to disseminate and translate the intervention into practice across the healthcare organization.

Step 19: Disseminate findings.

Findings were disseminated internally to stakeholders, leadership, and staff via a PowerPoint presentation. External messaging may include podium conferences, poster presentations, and published reports in appropriate professional journals.

Theoretical Framework

Change Theory

The behavior change model used for this project is Lewin's Change Theory, which has three phases: Unfreeze, Change, and Refreeze (Appendix D).

Unfreeze

The first step in initiating an organizational change is to unfreeze the current behavior, recognizing the difficulties related to stress and anxiety of the UAP that can lead to burnout, consequently impacting the organization. Self-care and *well-being* should be at the forefront as an organizational cultural norm to maintain equilibrium. Kotter (2007) states the importance of showing how new approaches, behaviors, and attitudes can improve performance as new behaviors are rooted in social norms and shared values (p.102). At this stage, communicating the vision for the change with all stakeholders is imperative for buy-in, allowing the change to occur. Stakeholders included facility leaders, the care partner trainer, the UAP scheduler, and the UAP. Details of why the change is necessary, the benefits, and the advantages would be explicitly communicated to gain support, recognizing that change is complex and disruptive to the standard workflow; however, this is a necessary but temporary disequilibrium to move toward a change of *self-care* and *well-being*. The stress and anxiety experienced by the UAP can lead to burnout, a negative disequilibrium. Moreover, the clinical environment will become unbalanced due to the side effects of burnout that lead to staffing issues (attrition rates, sick calls, increased workload,

and understaffing), decreased quality of patient care, and reduced resident satisfaction rates, but not limited to just these effects.

To change negative behavior, all involved need to decipher it through an examination of *mindfulness*—time allowed for the process, application, and decision to adjust to this positive behavior is necessary during the period of disequilibrium. Proffering *mindfulness* training (reminders) by encouraging continuous utilization permits the influence of change.

Change

During this phase, good communication is essential for planning and implementing the Mindfulness training program; according to Mitchell (2013), robust and open communication across teams strengthens infusing change. Each step of the *mindfulness* training program was executed in detailed collaboration with leadership and other stakeholders. The project lead directed and monitored all aspects of the project.

Refreeze

After the implementation of the *mindfulness t*raining program, data was collected to evaluate the intervention and monitor for stability and continued intervention support to be considered complete; this would be assessed through review with the stakeholders (Manchester et al. 2014). The intervention aims to be a sustainable wellness program across the organization; moreover, *mindfulness* skills utilization may be apparent in the UAP, demonstrated through behaviors such as decreased sick calls and turnover. Continued support of the process and stakeholders will continue, and refreeze will occur. The organizational system will adopt *mindfulness* training to promote *self-care* and enhance all employees' *well-being*.

Methods

Study Design

This EBP quality improvement project used a pre-post design with the same participants to evaluate an eight-week *mindfulness* training educational program for currently staffed Unlicensed Assistive Personnel. The project lead collected baseline data before the training session and included an initial two-minute *mindfulness* introduction video from the Palouse MBSR course.

Setting

This intervention was implemented within an Eastern healthcare facility that provided independent living, assisted living, memory care, and healthcare center services. It is part of an organization with three campuses generally offering the same services, including hospice care and rehabilitation. The Eastern healthcare facility serves approximately four hundred and fifty residents and has about one hundred UAPs represented from different countries.

Participants

The project participants were staffed Unlicensed Assistive Personnel addressed as Care Partners at their facility. As this was voluntary participation, lack of interest in the project and attrition rate were considered; therefore, it was estimated that approximately [n=30] participants would enroll as outlined in the methodology map (Appendix E). Inclusion criteria: All staffed UAP full-time, part-time, and per-diem and worked specific or across shifts. The interested participants were to engage in an 8-week *mindfulness* training program and communicate in written and verbal English. Exclusion criteria: Participants skilled in *mindfulness* practices.

Recruitment

A convenience sample was used to recruit participants after the Eastern healthcare facility granted permission to conduct the *wellness* initiative intervention (Appendix F) and the approval

of the human subject determination. In addition to in-person recruitment efforts (Appendix G), a recruitment letter and flyer were emailed to the participants, along with in-person recruitment efforts to inform the UAP of the DNP scholarly project.

Consent Procedure

The UAP that volunteered for the eight-week *mindfulness* training received an email attestation of the Informed Consent (Appendix H) adapted from the George Washington University Office of Human Research document. Consent is a requisite for participating subjects to receive competent information to make an informed decision prior to enrolling in any study (Monico et al., 2008), detailing the project's steward that participation was voluntary and that they could withdraw from the project at any time; moreover, the purpose of the scholarly project, the reason they may choose to participate or not participate, what their participation entails, and the benefits gained from participating in this scholarly project. The consent also ensured that every effort was made to keep participants' information confidential. The project lead's contact information was furnished for further information on the scholarly project.

Risk/Harm

There was no anticipated harm or risk posed to the participants during any phase of the DNP project; however, the protection of participants according to the *common rule* was considered by following all ethical conduct when working with human subjects (White et al., 2020). The project design allowed anonymous data collection and secured storage through the REDCap online database. Participation was voluntary, and withdrawal from the project could occur without consequence.

Cost and Compensation

There is a negligible cost for this DNP project. The cost for participants was their time, which may not be deemed compensational. The cost of data collection compared to its relative value in the project evaluation assessed how many team members would be involved in the data collection. Evaluation of the project did not incur any financial cost to the facility; however, the cost in terms of time was conceivably substantial. Two small incentives, a certificate of completion (Appendix I), and a ten-dollar Target gift card were proffered to the UAP for their participation in the *mindfulness* training.

Project Intervention

The intervention for this project focused on a *mindfulness* training program that aimed to promote *self-care* behaviors for UAP. The *mindfulness* training was an eight-week modified self-directed program utilizing the free online Palouse Mindfulness-Based Stress Reduction (MBSR) training course. (Palousemindfulness.com, 2023; Palouse Mindfulness (n.d). The Palouse Mindfulness is a free online eight-week MBSR training course created by a certified instructor based on the program founded by Jon Kabat-Zinn at the University of Massachusetts Medical School (Palouse Mindfulness, n.d). The MBSR course is taught through the notable work of Mindfulness teachers: Zen master Thich Nhat Hanh, Jon Kabat-Zinn, Tara Brach, Jack Kornfield, and many others. The Palouse's eight weeks of *mindfulness* Training commenced with awareness and movement through mindfulness practices for meditation: raisin, rain, walking, silence, sitting, mountain, lake, loving-kindness, body scan, and yoga, all self-directed through videos and readings by *mindfulness* teachers assigned each week.

The intervention for this *mindfulness* training was facilitated by the project lead for the UAP to engage in self-directed weekly *mindfulness* activities over eight weeks and incorporate what they learned into daily practice at their convenience. A lesson plan for this intervention

(Appendix J) displays a modified version of the Palouse MBSR course. The *mindfulness* training commenced with an introduction to *mindfulness* with topics covered (How to self-care and What is *mindfulness*?) via a three-minute video instruction and demonstration on *mindfulness* from the Palouse MBSR course (Appendix K), followed by weekly *mindfulness* activities with attached links for which the UAP were to engage, with the average activity being approximately thirty minutes. The total time spent on assigned self-directed *mindfulness* activities over the eight weeks averaged two hundred and forty minutes.

During the first four weeks of the *mindfulness* training, they covered comprehensive topics related to thoughts, stress, and its effects. In the following four weeks, *mindfulness* activities included *mindfulness* breathing, body scans, and *mindfulness* meditation exercises, which included sitting, silence, and walking, which were assigned to promote *self-care.* Each weekly *mindfulness* practice (s) was generally around thirty minutes. There was no rigid proposed structure or daily homework included in this training. This project's *mindfulness* training only recommended weekly access to the modified course-assigned materials and daily *mindfulness* practice for five to thirty minutes to cultivate *mindfulness*. Conversano (2020) reports that *mindfulness* interventions were effective at improving *mindfulness* levels and were conducted for one to three minutes of guided practice. The standard daily home practice for Mindfulness-Based Interventions was twenty to forty-five minutes (De Vibe et al., 2013; Wahbeh, Goodrich, & Oken, 2016).

Instruments used for intervention, including the Mindful Self-Care Scale-Brief (MSCS-B) and the IHI-Well-being Assessment Survey, were administered pre and post-intervention, as were the demographic survey. The Palouse MBSR Activity and Frequency Questionnaire was administered at weeks four and eight.

Outcomes Measured

Demographic Survey

The demographic survey created by the project lead collected data on age, gender, ethnicity, nationality, employment status, educational level, years of work experience, and specialized areas (Appendix L).

Mindful Self-Care Scale-Brief (MSCS-B)

The Mindful Self-Care Scale- Brief (MSCS-B) measured participants' pre and post-intervention Self-care behaviors. The MSCS-B is 24 item Likert Scale that came into development to assess mindful *self-care* in everyday life and address six domains (Cook-Cottone & Guyker, 2017) to assist in identifying areas of strengths and weaknesses in Mindful Self-Care (Hotchkiss & Cook-Cottone, 2019); (Appendix M). MSCS-B showed improved fit relative to the 33-item scale showing more substantial evidence of healthcare professional wellness (Hotchkiss & Cook-Cottone, 2019). The Mindful Self-Care Scale (MSCS) 33 items measure the self-reported frequency of self-care behaviors, how much or how often within the past week (7 days) with Likert response (1 = Never (0 days), 5 = always (6-7 days) along with reversed scoring. There are subscales of Physical Care, Mindful Relaxation, Supportive Structures, Supportive relationships, Mindful Awareness, and Self-compassion and Purpose. It is a valid and standardized tool used to assess the variety and frequency of self-care strategies. Internal consistency reliability -Cronbach's coefficient alphas were 0.89 (Cook-Cottone & Guyker, 2017). Dr. Cook-Cottone granted permission to use the MSCS-B and the scoring system (Appendix N).

IHI -Well-Being Assessment Survey

The Institute for Healthcare Improvement (IHI) 100M Lives Well-Being assessment tool is a 12-item questionnaire to measure and track improvement in health, Well-being, and equity

(Stiefel, Riley, & Straszewski, 2020). The questionnaire comprises items from validated instruments, was created collaboratively with experts in the field, was tested in member organizations and communities, and is considered a self-anchoring measure (IHI.org, 2023). The Well-being tool will assess participants' Well-being pre and post Mindfulness intervention. The questions are asked in a ladder format, with the top of the ladder representing the best possible life and the bottom of the ladder's worst possible life, with 10 being at the top and 0 at the bottom (Appendix O). The tool is licensed under Creative Commons and is free to share and adapt as long as credit is given (Appendix P)

Palouse MBSR Activity and Frequency Questionnaire

This post-intervention questionnaire developed by the project lead consists of quantitative and qualitative questions to collect data on usage, preferred activities, and time spent engaged in the activity (Appendix Q).

An outcome measures table (Appendix R) was created to assess measures outcomes and ease of dissipation of tools (Garcia & Abrahao, 2021), as each tool consists of several domains.

Project Timeline

This project commenced in the fall of 2023, with the recruitment of participants, the *mindfulness* intervention occurred in October, and the initiative concluded in February 2024. A Gantt (Appendix S) chart displayed the detailed monthly projected time plan.

Resources Needed

Resources needed for the *mindfulness* training included email addresses, computers or mobile devices, REDCap data management system, and SPSS. Support and buy-in from the project site leaders and stakeholders were imperative for the success of this project.

Evaluation Plan

This DNP project approach distinguished the appropriate methodology and tools for measurement to evaluate the usefulness and effectiveness of the *mindfulness* training intervention to promote *self-care* and enhanced *well-being*. The short-term goal was for UAP to show increased attention and awareness of being mindful. The intermediate goals were awareness, attention to *self-care* behaviors, and applying *mindfulness* into daily practice. The long-term goal was to implement *mindfulness* training for all employees across the organization. A logic model (Appendix T) guided the evaluation plan.

The Acceptability Intervention Measure (AIM) and the Feasibility of Intervention Measure (FIM) are tools utilized in the evaluation of this project (Appendix U). Weiner et al. (2017) described *acceptability* as "the perception among implementation stakeholders that a treatment, service, practice, or innovation is agreeable, palatable, or satisfactory. The authors defined *feasibility a*s the extent to which a new treatment or innovation can be successfully carried out within an agency" (P.2).

The AIM and FIM measures have several pragmatic qualities: No cost to use, reliability, and ease of completion. It takes less than five minutes to complete each measure, and the scale's value ranges from 1 to 5 (Weiner et al., 2017). The scores 20 and 19 for the AIM and FIM demonstrated the acceptability and feasibility of the intervention.

Data Analysis, Maintenance & Security

Collection of Data

The Research Electronic Data Capture (REDCap) platform is the management system used to collect and store data for all surveys and instruments. Data was initially collected when participants consented to be part of the project and commenced with the electronic demographic survey, followed by MSCS-B and the IHI-Well-Being Survey data collection. The pre-post data

collection was imperative to assess the mean scores for the MSCS-B and IHI-Well-Being and compare the collected pre and post-intervention mean scores. At the beginning of each week, on Sunday for eight weeks, the project lead sent *mindfulness* lessons via email for the week's activity.

Data Analysis

Basic descriptive statistics were used to examine the participants' characteristics, the variables' distribution, and the participants' qualitative analyses during the mindfulness training. The basic descriptive statistics analyzed, including mean (SD), min, max, age, and level of education. Frequency (%) of years of work experience, department or unit assigned, and shift worked. Data analysis was finalized using the Statistical Package for the Social Science (SPSS) Analysis software. Self-care behaviors were analyzed using a paired sample t-test to compare the same group and dependent variables. Mean scores of MSCS-B and the IHI-Well-Being Assessment tool were evaluated for pre-intervention and post-intervention comparisons through descriptive statistics. The Palouse Mindfulness Activity and Frequency questionnaire inferences were made based on the data.

The analysis plan to meet the Aim objectives:

- The Demographic Survey was benchmarked at 100% percent response.
- The benchmark for the MSCS-B was to increase the mean score by 50% from the baseline line score for each category within eight weeks.
- The IHI- Well-Being tool was benchmarked at 50% to increase mean scores from the baseline for each category within eight weeks.
- The Palouse MBSR Activity and Frequency Questionnaire probed participants' experience with the *mindfulness* activities more in-depth with a set benchmark for

four out of six activities, frequency twice daily, and a minimum of 15 minutes engaged in an activity was considered a success.

Data Maintenance and Security

The DNP project lead handled all responsibilities for the maintenance and security of the data related to this project. Rosenbaum (2010) stated that there is a responsibility for data stewardships and governance, which is imperative to managing the data collection and analysis throughout the process. The data collection instruments were free of identifying information and stored securely. Only the project lead and appropriate team members accessed the data. A data dictionary was utilized to manage data items.

The Research Electronic Data Capture (REDCap) platform was the management system to collect and store data instruments and surveys. RedCap is a secure, web-based software platform designed to support data capture for research studies, providing an intuitive interface for validated data capture (Harris et al., 2009); REDCap allows for automated export procedures for seamless data downloads to common statistical packages (Harris et al. 2019). The REDCap web application supports clinical research development, reduces the costs of research conducted, and allows for secure data storage (Garcia & Abrahao, 2021). All survey responses were anonymous, and no identifying information was collected.

Data from the surveys collected through REDCap was exported to the Statistical Package for Social Science 29 (SPSS) and was analyzed with a paired t-test using the analysis software to compare the same group for the dependent variables of *self-care* and *well-being*. The data analysis employed descriptive statistics, which included the mean score, paired t-test, standard deviation, minimum and maximum, and calculated probability significance of the p-value for the MSCS-B and the IHI-Well-Being Assessment Survey. The Demographic Survey was analyzed

by looking at the percentages of the measured variables, frequency, mean, and standard deviation. The project lead and statistician checked to ensure data entry accuracy input into SPSS. Missing data is identified in SPSS and displayed with a blank dot called the missing system. The data was cleaned, and the missing values were unanswered questions. They were replaced with 9999999 as this value was not relative to the data set. All incomplete data sets were retained as the missing data was handled appropriately.

Results

The implementation of the *mindfulness* training program for the UAP (n=9) participated in completing the pre-surveys; however, the post-survey results showed an attrition rate of 0.2% (n=7) completed the post-surveys. The data was aggregated for pre and post-intervention analysis.

Demographics

The UAP who engaged in the mindfulness training were female and varied in age, indicating an interest in improving *self-care* and *well-being* regardless of age, with a mean score of 41.56 (SD = 13.685). See Appendix V for the demographic sample.

Evaluation of objectives:

Increase the Unlicensed Assistive Personnel's *self-care* behaviors after applying a wellness initiative; the *mindfulness* training program showed *self-care* behaviors measured before and after the *mindfulness* training with the MSCS-B using descriptive statistics to compare the mean scores; in addition, A paired t-test compared the pre-and post-mean scores of the MSCS-B which showed an increase in *self-care* behaviors and proved to be significant with a p-value < 0.1 (results in Table 3).

Increase *well-being* of the Unlicensed Assistive Personnel after applying a wellness initiative, a *mindfulness* training program measured with the IHI-Well-Being instrument was also evaluated with descriptive statistics to compare pre and post-mean scores and a paired t-test analysis for an increase in *well-being*; however, it showed no significance, Tables 2 and 3 show the results, and Appendix W displays the participants' pre-post means scores.

Improve the Unlicensed Assistive Personnel's adoption of *mindfulness* daily practices after a Wellness Initiative-Mindfulness training program; the Palouse MBSR Frequency and Activity Questionnaire measured the participants' engagement in the *mindfulness* activity. The body scan was the most preferred activity of the six mindful activities, followed by walking, loving-kindness, and mindful breathing. The most popular times to engage in an activity were morning and night. The most reported time spent on an activity was twenty-five to thirty minutes, with the frequency being three or four times per day.

Five out of seven participants reported their thoughts on the *mindfulness* activities:

"During the body scan, I realized my mouth was tense and felt release after concentration of the guided session."

"The body scan helped me to understand my body, and the mapping made me pay attention to where I felt emotion."

"When I feel stress at work, I can feel the tension building in my shoulders, and I would pause to allow myself release of the tension."

"With the body scan, I view myself as interesting."

"The walking meditation and loving kindness brought me inner peace and unconditional well-being for myself and others."

"During mindful breathing, allow me to relax after learning to concentrate on my breaths."

"I plan to continue some activities in the long term."

Discussion

There were limitations to this evidence-based QI project, which included the small sample size and the length of the training. Maintaining the anonymity of the surveys created some difficulty in paring the survey results. A larger sample size may have provided statistically significant results identifying a relationship between *self-care* and *well-being*. The length of the training and perhaps time constraints may have contributed to the small sample size and attrition rate, as well as the omission of some survey questions related to anonymity concerns impacting the outcomes. Well-being results perhaps indicated the difficulty of measuring as individuals have different definitions of *well-being,* which may depend on what part of life is impacted or different questions about *well-being* that need to be asked.

Implications

Implications for Practice are beneficial in preventing staff shortage and high attrition rates due to burnout; the intervention results show that *mindfulness*, a simple and feasible tool, can help promote *self-care* and enhance *well-being*. The anecdotal reports indicate that *mindfulness t*raining is a valuable intervention to promote *self-care* as it brings attention to the self and what is being experienced in the present time and allows the individual to manage their

emotions. The health care system that prioritizes *self-care* and *well-being* denotes the value of a healthy work environment.

Implications for Healthcare Policy indicate that implementing a policy for *mindfulness* practices as part of UAP orientation will ensure supportability for *self-care*, health, and *well-being* and can lead to health and wellness programs.

Implications for Executive Leadership are the recognition of burnout, the importance of safeguarding the health of their staff, and the importance of quality and safe patient care. Leadership can participate in *mindfulness* activities and lead by example to embrace *mindfulness* as the foundation of *self-care* and *well-being*, prioritizing it as part of fostering a healthy work environment.

Implications for Quality and Safety indicate that when the *self-care* and *well-being* of the UAP are in good equilibrium, they are healthy in mind, body, and soul, which projects in the care provided. The UAP has tools to recognize what emotions they are experiencing and know how to respond positively, which will ensure that they are providing quality and safe patient care that benefits the organization.

Plans for Sustainability and Future Scholarship

Sustainability is to be achieved by implementing another iteration of *mindfulness* training for the UAP at the facility, which can be highly effective in reducing burnout and attrition. Sustainability can then occur across the organization as a positive result. Dissemination brings *mindfulness* to healthcare organizations' awareness and incorporates this tool to secure a healthy workforce and environment.

Plans for Dissemination

Dissemination will occur with the facility leadership and the submission of the abstract to organizations that extend an invitation to present a poster or podium presentation that is deemed appropriate, including any opportunities for publication.

Conclusion

Burnout in the healthcare workforce is known, and it is also known from the research and evidence that MBSR activities are holistic tools that improve and maintain *self-care* and *well-being*. Its attributes of being cost-effective and self-directed demonstrate its usefulness. The UAP, extraordinaire in their work, deserve care and recognition, as they, too, are stressed and burned out. More initiatives on *mindfulness* are needed and recommended in this population to ensure their value as part of the healthcare system. This intervention suggests that *mindfulness* training promotes *self-care* and may enhance *well-being*. Self-care benefits are essential to the UAP to build resilience and prevent burnout. Healthcare organizations must embrace *mindfulness* training as it lends itself to a shift in culture: Better patient interaction, quality of care, communication, and a decreased attrition rate.

Mindfulness is a way to be present in the world with awareness of self and thoughts, acknowledging what is felt or experienced without judgment. Those who recognize this can engage in *mindfulness* exercises during cycles of discomfort or stress to better cope with challenges when they arise. According to Chmielewski et al. (2021), *mindfulness* interventions aim to create a possibility to be more aware of one's own experience and to recognize stressors while regulating thoughts and feelings to stop harmful effects. "It is important that healthcare professionals make *self-care* a priority so that they can attend to their *well-being*." (Shapiro et al., 2008, p.324); hence, the *well-being* of all patient care providers is to be purposeful. Henshall et al. (2020) said that taking better care of the nursing workforce commands significant intimation

of increased efficiency within the healthcare system, which benefits the quality and safety of patient care.

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Appendix A

SWOT ANALYSIS

	Helpful To achieving the objective	**Harmful** To achieving the objective
Internal Origin {Attributes of the organization}	**Strengths** ▪ Transformational leadership. ▪ Stable leader structure. ▪ DEI initiatives. ▪ Long-standing team members. ▪ They are embedded into the community. ▪ Orientation for UAP ▪ Educational partnerships. ▪ Diverse workforce. ▪ Growth opportunities for staff. ▪ Partnership with local colleges. ▪ Great sense of community	**Weaknesses** ▪ High acuity of patients. ▪ Staffing shortage ▪ Increase workload. ▪ Increase attrition rate: UAP. ▪ Lack of holistic training programs for UAP
External Origin {Attributes of the organization}	**Opportunities** ▪ To Implement Holistic training programs for the clinical staff. ▪ Sustainability of clinical staff. ▪ Building partnerships. ▪ Workforce recruitment efforts	**Threats** • The Covid-19 challenges ▪ Clinical staff burnout. ▪ Increase in nursing staff attrition rate. ▪ Increase risk for errors. ▪ Decrease in quality patient care. ▪ Lack of buy-in from stakeholders. ▪ Adverse reaction to an outsider. ▪ Other Long term care facilities in the area with job opportunities.

Appendix B

Evidence Table

Article #	Author, Date & Title	Type of Evidence	Population, Size, Setting	Intervention	Findings that help answer the EBP Question	Measures Used	Limitations	Evidence Level & Quality	Notes
1	Burton et al. (2017) How Effective are Mindfulness-Based Interventions for Reducing Stress Among Healthcare Professionals? A Systematic Review and Meta-Analysis	Systematic Review and Meta-analysis. Eight studies were examined.	Healthcare Professionals(HCPs): Nurses, Doctors, Midwives, mental health, occupational therapists, educational professionals, and service industry employees. Sample sizes varied from 16 to 52 participants	Mindfulness-Based Interventions (MBIs).	The review indicates the potential for MBIs to reduce stress in HCPs.	Measures for stress: Perceived Stress Scale (PSS), Mental Health Professional Stress Scale, Depression Anxiety Stress Scale, Survey of Recent Life Experiences, and a Visual Analogue Scale. Measures of Mindfulness:	For this review, stress was the only outcome-focused. There were inconsistencies with follow-up data across the studies; consequently, the long-term impact of Mindfulness-Based interventions could not be drawn.	Level II Quality Low	A variety of self-report outcome measures were used across the studies. Four studies used measures of Mindfulness. Two studies used the Mindfulness Attention Awareness. The Toronto Mindfulness and Five

						Mindfulness Attention Awareness Scale, Toronto Mindfulness Scale, and the Five Facet Mindfulness Questionnaire (FFMQ).			Facet Mindfulness questionnaire were each used by one study.
2	Conversano et al. (2020) Mindfulness, Compassion, and Self-Compassion Among HealthCare Professionals: What is New? A Systematic Review	Systematic Review- the number of articles that met the inclusion criteria was 58 Randomized Control Trials (RCTs 4). Studies with pre-post measurements (24) Cross-Sectional Studies (12) Cohort studies (11)	The population included nurses, doctors, midwives, educators, social workers, and therapists. Settings of studies were in a variety of healthcare facilities.	Mindfulness-Based Stress Reduction (MBSR) Mindfulness Interventions (MIs)	Findings indicate there is a potential for MBSR and MI as tools to enhance Mindfulness, self-compassion, and quality of life in HCPs. MBIs have been seen to increase awareness levels and strategies to cope with stressful situations; while reducing perceived stress,	Quality assessment of the studies reviewed was based on Measurement Tool to Assessed Systematic Reviews-2 (AMSTAR-2). Review of the measures used in the studies most frequent FFMQ, Maslach Burnout Inventory Subscale, and Mindfulness Attention Awareness	Inclusion criteria were limited to English, Italian, and peer review articles which may have limited the number of articles reviewed. Exclusion of studies with patient care technicians, nurse aides, and clinical technicians,	Level III Quality High	A variety of mindfulness skills were examined. Each study used a variety of measures based on outcomes. Mindfulness programs varied from 2-10 weeks. Average session time was 30 mins; with 1-10 minutes for guided periods of Mindfulness.

		Qualitative studies (7)			anxiety, and depression. Mindfulness training was the most used interventional strategy that effectively improved Mindfulness and self-compassion.	Scale (MAAS),			
3	Daigle et al. (2018) Mindfulness-based Stress reduction Training yields improvement in well-being and rates of perceived nursing errors among hospitals nurses	RCT with matched pairs	Registered nurses and Licensed Practical nurses (N=75). Intervention Group (IG= 38). Control Group (CG = 37)	MBSR	MBSR programs produced moderate improvement during distress. Treatment satisfaction was high and beneficial at work and home.	Tension Anxiety Subscale of the Profile Mood state (POMS-TA). Nursing Error Rating Scale. Pre and Post Self Report	Reliance on self-report questionnaires and a measure of perceived improvement instead of an objective measure. The positive impact of MBSR may be overestimated due to social desirability.	Level I Quality Good	Addressed burnout to perceived errors.
4	Lomas et al. (2017) A Systematic Review of the impact of Mindfulness on the well-	Systematic Review Eligibility criteria yielded 81 papers RCT	N= 3,805 participants comprised the studies. Intervention Studies (n = 2,645)	MBIs	MBIs had a positive effect on most outcome measures. All studies suggest	Quality Assessment Tool for Quantitative Studies (QATQS).	QATQS quality assessment, only a few studies scored highly in all respects. For	Level II Quality High	Analysis of Mindfulness and well-being.

	being of healthcare professionals	Non-Intervention studies	Non-Intervention Studies (n = 1,160) Physicians 9 n= 9) Nurses (n = 16) Mental health professionals (n = 8) Disability professionals (n = 4) Healthcare professionals (n= 20) Therapist, psychologist and counselors (n=24)		Mindfulness can reduce anxiety, depression, and other mental health issues while enhancing well-being. The outcomes seemed to be fairly distributed across different healthcare professions		studies with interventions (66), only 39% involved a CG, whereas 30% conducted an RCT which made it difficult to observe positive changes from Mindfulness Lack of randomization of participants in CG can compromise results due to baseline characteristics effects between the groups. The lack of Heterogeneity to the type of MBI and outcomes measure		

5	Mackenzie et al.(2006) A brief mindfulness-based stress reduction intervention for nurses and nurse aides.	RCT	Registered Nurses and Nurse aides (N = 30) Geriatric teaching hospital	MBSR	ANOVA was used to analyze the effectiveness of the intervention There is a potential for mindfulness training to treat and prevent stress related problems to promote coping.	Maslach Burnout Inventory Smith Relaxation Dispositions Inventory Intrinsic Job Satisfaction Subscale Satisfaction with life Scale	The sample size limits generalizability and reduced statistical power. The participants were heterogeneous, and there was no follow up to know the effects of the program after completion.	Level I Quality Good	
6	Manotas et al. (2013) Association of brief Mindfulness Training with Reduction in Perceived Stress and Distress in Columbian health Care Professionals	RCT	Healthcare Professional (N =131) IG (n = 66) CG (n = 65) Hospital system	MBSR	After Mindfulness Training (MT) participants reported lower levels of reduced perceived stress, depression and anxiety. Scores on non-judging and observation	The Five Facet Mindfulness Questionnaire (FFMQ) PPS BSI-18	No follow-up after a 4-week intervention. Participants' homework was not monitored. Included only individuals that participated in at least three of the four intervention sessions.	Level I Quality Good	

					facets of FFMQ were increased after MT.		The data to conduct an intention to treat analysis: whether participants who did not complete the study differ from those that did. There was the possibility of reporting regarding anxiety and distress.		
7	Muir, J.K. & Keim-Malpass, K (2020) The Emergency resiliency Initiative A pilot Mindfulness Intervention Program	Mixed Methods pre/post-study.	Registered Nurses (RN) (n =26) Patient Care Technicians (PCT) (n=9) Urban Level 1 trauma center	Emergency Resilience Initiative (ERI) adapted from the shortened version of the MBSR model	RNs demonstrated a significant decrease in emotional exhaustion (p =.01) in the pre to post-test period. The PCT group showed decrease in emotional exhaustion scores (p =	MBI Human services Survey and Dedoose software management application.	Clinicians' self-enrollment into the study leads to a potential for self-selection bias. Results may lack generalizability as all participants were selected from the same	Level II Quality Good	Holistic perspective

					.03). for the pre to post-test period. Feedback from the participants highlighted the practical application of Mindfulness, whereas it cultivated a sense of community. There was a 74% retention among participants to all the components of the training and surveys. The MBI was It was acceptable for the setting.		setting in the medical center. There may have been some impact for those participants who attended all sessions compared to those that watched the sessions without group engagement. The lack of a CG contained self-report questionnaires and self-reporting meditation frequency measures.		
8	Querstret et al. (2018) The effects of an Online Mindfulness	Randomized waitlist Control Trial (RCWT)	General population (N = 118). Female (n =95). IG (n= 60). CG (n = 58). Online	Online Mindfulness-based cognitive Therapy (MBCT).	ANCOVA analysis showed a significant reduction in perceived	PSS-10 Patient Health Questionnaire (PHQ-9)	The study's design did not allow for multiple treatments to	Level I Quality Good	Participants were followed up at 3 and 6 months

	Intervention on Perceived Stress, Depression and Anxiety in a Non-Clinical Sample: A Randomized Waitlist Control Trial				stress (p < 0.001, d = - 1.25); Depression (p < 0.001, d = - 1.64); and Anxiety (p < 0.001, d = - 1.09); with 95% CI for each outcome. ANCOVA analysis showed a significant increase in the level of the mindfulness facets, except with NR.	Generalized Anxiety Disorder (GAD-7) Five facets Mindfulness questionnaire short Form (FFMQ-SF) Acting with Awareness (AA), Observing (OBS); Describing my feelings (DES), Non-Judging (NJ), and Non-reactivity (NR	be assessed against each other. The amount of data for the meditative practice sessions was not collected. The moderate to severe levels of self-reported depression in both groups at baseline raised the question about the generalizability of the findings.		
9	Sarazine et al. (2020) Mindfulness workshops Effects on Nurses' Burnout, Stress, and Mindfulness Skills	Quasi experimental	Nurses (N= 52) from Midwestern urban Academic medical center and a community hospital.	MBSR	MBIs decreased burnout and stress and increased Mindfulness	PSS, Maslach Burnout Inventory-Human Services Survey (MBI-HSS). Cognitive and Affective Mindfulness Scale-	Small sample size. Bias may have played a role as some participants were involved in unit-level mindfulness interventions.	Level II Quality Low	Four hour workshop Results were not significant

						Revised (CAMS-R	The study was not representative of all areas of nursing. Power of analysis was not done. Follow-up visits were missed resulting in a low survey response. The initial workshops were free, subsequent workshops charged a fee which may have contributed to the low enrollment numbers.		
10	Spinelli et al. (2019) Mindfulness training for	Meta-analysis on RCTs	Thirty-eight studies were examined on healthcare professionals.	MBSR, MBIs, and Meditation	Mindfulness-based interventions were found to have a	A variety of measures were used for the studies outcomes;	A moderate to high heterogeneity. When exploring	Level II Quality Good	Intervention characteristics assesses.

	healthcare professionals and trainees: A meta-analysis of randomized controlled trials		n=2505 (75.88% female). Twelve studies with medical students/residents, seven nursing; the others were mixed with psychology and other specialties.		generally small to moderate effect in the reduction of symptoms related to anxiety, depression, stress, and burnout. Well-being overall showed a small to significant moderate effect. Multifaceted MBIs revealed the importance in reducing stress.	most commonly used Perceived stress Scale (PSS), Acceptance and Action Questionnaire (AAQ), CES-D, Beck Depression inventory (BDI), Brief resilience Scale (BRS), and Inventory Mindfulness Scale.	MBSR effects. MBIs included substantial homework and home practice. Some studies found that participants did less than the prescribed amount of practice and reduced practice over time. Most of the studies did not follow up, therefore interpretation of long term effects of the intervention could not be assessed.		

Appendix C

JHNEBP-PET Tool

EBP Work Plan										
Initial EBP question:										
EBP team leader(s):										
EBP team members:										
Goal completion date:										
Steps		Month								
		1	2	3	4	5	6	7	8	9
Practice Question & Project Planning	1. Recruit interprofessional team									
	2. Determine responsibility for project leadership									
	3. Schedule team meetings									
	4. Clarify & describe the problem (App. B)									
	5. Develop & refine the EBP question (App. B)									
	6. Determine the need for an EBP project									
	7. Identify stakeholders (App. C)									
Evidence	8. Conduct internal & external search for evidence									
	9. Appraise the level & quality of each piece of evidence (Apps. E/F)									
	10. Summarize the individual evidence (App. G)									
	11. Synthesize findings (App. H)									
	12. Develop best evidence recommendations (App. H)									

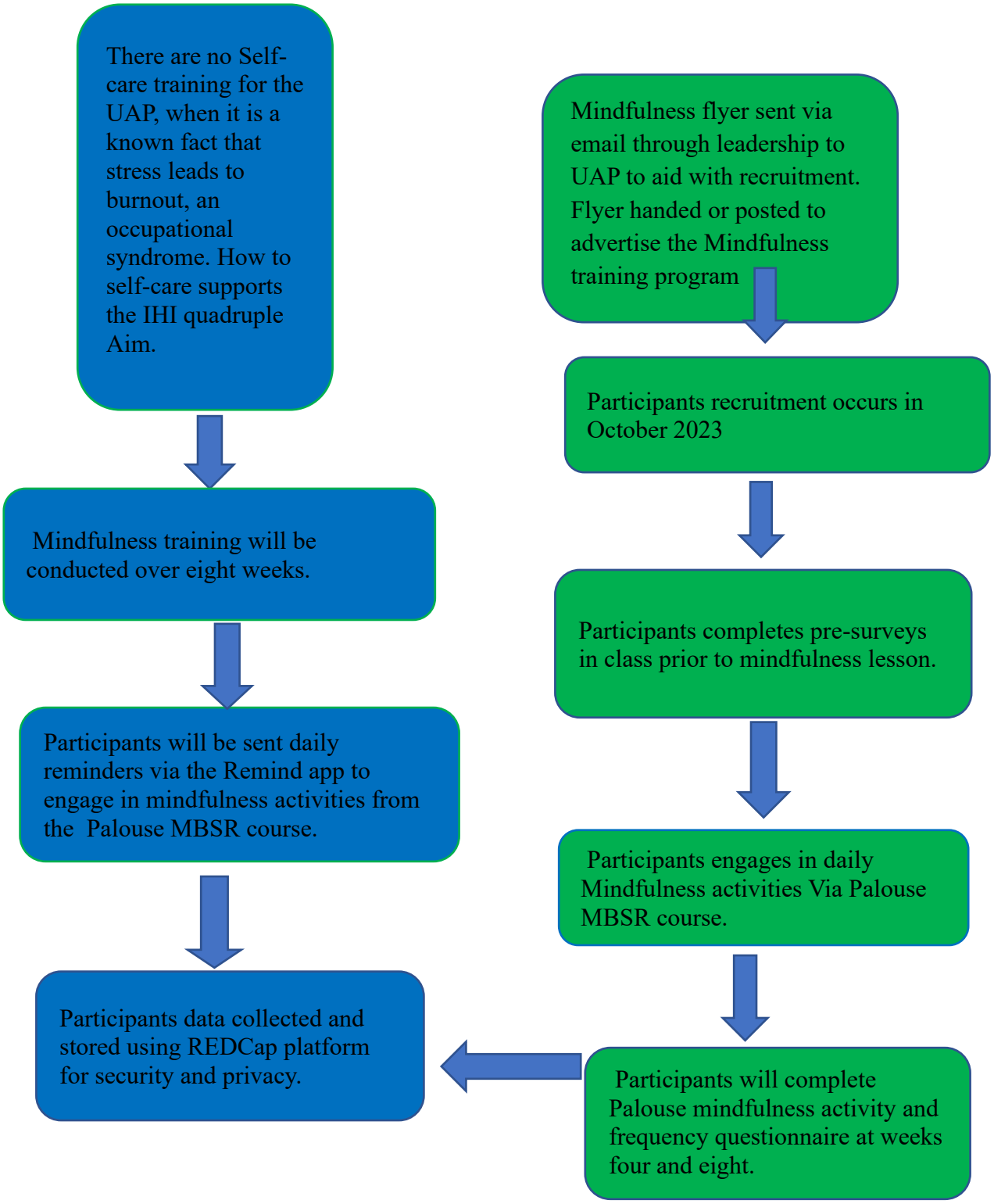
Translation	13. Identify practice setting–specific recommendations (App. I)									
	14. Create action plan (App. I)									
	15. Secure support & resources to implement action plan									
	16. Implement action plan									
	17. If change is implemented, evaluate outcomes to determine if improvements have been made									
	18. Report results to stakeholders (App. C)									
	19. Identify next steps									
	20. Disseminate findings (App. J)									

Appendix D

Lewin's Change Model

Appendix E

Methodology Map



Appendix F

Clinical Site Permission Letter

[redacted] June 19, 2023

Dear Sir/Madam:

Please be advised that Julia Aurora Clarke, DNP student at George Washington University School of Nursing, is granted permission to do her research project here at [redacted].

If you have questions, please contact me [redacted]

Sincerely,

Catherine

Catherine E. Farmer, MSN, RN, LNHA

Director of Clinical Services

Appendix G

Recruitment letter and Flyer

14 August 2023

Dear Community members,

I am conducting a Mindfulness training project to promote Self-Care behaviors and Enhance Well-being among Unlicensed Assistive Personnel. This wellness initiative will be implemented during eight weeks as *mindfulness* training to offer tools for Self-care to enrich your Well-being to manage workload stressors and burnout.

This program is being developed as part of a Doctor of Nursing Practice project, and participants are asked to examine Self-care behavioral changes. The study aims to promote Self-care and enhance Well-being through a free guided Mindfulness course. Participation in this project is of voluntary interest, and thus it is not mandatory. All the data collected for this project will be protected through anonymity and confidentiality.

To be eligible to participate in this project, participants must be employees from any healthcare facility department. It would be preferred if participants had no recent experience with Mindfulness training.

I hope you will consider participating in this project.

If you have any questions regarding this project, please feel free to contact me at 917-861-8311 or email jaclarke@gwu.edu

Sincerely,

Julia Aurora Clarke, MSN, RN, CNS


Mindfulness Training
What if you could learn Self-Care behaviors to manage daily stress through Mindfulness training?
Mindfulness activities include:
Breathing exercises
Meditation
Recreation (walking)
Affirmations
For more info please contact project lead Julia Aurora Clarke, MSN, RN, CNS:
Created by Kal Bartholomew
(917) 861-8311
jaclarke@gwu.edu

Appendix H

Informed Consent for Participation in a DNP Scholarly Project

Title of Study: A Wellness initiative: Mindfulness Training for Unlicensed Assistive Personnel to Promote Self-Care and Enhanced Well-Being.

Project leader: Julia Aurora Clarke, MSN, RN, CNS

Version Date: 14 August 2023

You are invited to participate in a Doctor of Nursing Practice- Evidence-Based Practice project under the direction of Julia Aurora Clarke of The School of Nursing at The George Washington University (GWU). Taking part in this Scholarly project is entirely voluntary. The status of your employment will not, in any way, be affected should you choose not to participate or if you decide to withdraw from the project at any time. Further information regarding this project may be obtained by contacting Julia Aurora Clarke, the project lead, at **(917) 861-8311.**

The purpose of this project is to implement a Mindfulness training program to promote Self-care and enhance Well-being for Unlicensed Assistive Personnel to manage workplace demands to reduce stress and burnout.

What are the reasons you might choose to volunteer for this project? Learning self-care behaviors to aid with stress management enhances your Well-being.

What are the reasons you might not choose to volunteer for this project? The weekly participation in a Mindfulness course, completing several surveys at varying times during the project, and the length of the project.

If you choose to participate in this project, you are asked to view a three-minute Mindfulness video, Engage in an eight-week Mindfulness course, engage in daily Mindfulness activities, and complete surveys: Mindful Self-Care Scale-Brief (MSCS-B), Well-being Assessment Survey, and demographical survey. All data collected from surveys and Mindfulness activities are essential to the success of this project. The total time you will spend connected with this project is eight weeks. You may refuse to answer any of the questions and stop participating in this project at any time.

Possible risks or discomforts you could experience during this project include there may be some loss of confidentiality due to completing the surveys.

You will benefit directly from your participation in the project. The benefits to science and humankind that might result from this project are promoting Self-care behaviors and Well-being for Unlicensed Assistive Personnel.

Every effort will be made to keep your information confidential; however, this cannot be guaranteed. You will not be asked to put your name or other identifiers on surveys; if email addresses or cell numbers show on the Data collection platform (REDCap), all identifying information will be deleted from the data storage. If the results of this research project are reported in journals or at scientific meetings, the people who participated in this project will not be named or identified.

The Office of Human Research of George Washington University, at the telephone number (202) 994-2715, can provide further information about your rights as a research participant.

To ensure anonymity, your signature is not required unless you prefer to sign it.

Your willingness to participate in this DNP scholarly project is implied if you proceed.
*Please keep a copy of this document in case you want to reread it.

Adapted from the GW ORH document (2019)

Appendix I

Certificate of Completion

Appendix J

Mindfulness Training Lesson Plan

Mindfulness Training Session	Total time
▪ Administration of pre-surveys and acceptance to participate in the project.	5 minutes
▪ Stress and Burnout ▪ What is Mindfulness? ▪ Palouse video: How to Self-care	3 minutes
Weekly Mindfulness activities https://palousemindfulness.com	33 minutes
Week 1 ▪ Palouse Mindfulness video: Being fully awake in our own lives. ▪ The Power of Mindfulness ▪ Mindfulness and the Body	
Week 2 ▪ The Monkey Business Illusion ▪ All it takes ▪ Mindfulness practice	29 minutes
Week 3 ▪ The Samurai and the Fly- Hanjin song ▪ Dealing with thoughts ▪ Meditation for difficult emotion	43 minutes
Week 4 ▪ Stress- A portrait of a killer ▪ How stress affects your brain ▪ Stop: A short mindfulness practice	14 minutes
Week 5 ▪ Body Scan	32 minutes
Week 6 ▪ Loving Kindness ▪ Walking meditation	19 minutes
Week 7 ▪ Sitting meditation	32 minutes
Week 8 ▪ Silent meditation	20 minutes

Clarke, JuliaAurora (2023)

Appendix K

Palouse Mindfulness MBSR

You are welcome to use whatever you find on this site, free of charge, for your own work and/or teaching. *All I ask is that you let people know it came from* ***palousemindfulness.com****, and that it is a free resource, so that they can find other materials on their own*

Appendix L

Demographic Survey

This survey is to examine the characteristics of the population.

How old are you?

What is your Gender?

- Female
- Male
- Transgender
- Nonbinary
- Prefer not to identify

What is your race/ethnicity?

- Black
- Latinx
- White
- Asian
- Native American
- Other

Are you an Immigrant

- Yes
- No

What is your level of education?

- Some high school
- High School

- College/university
- Other

How many years of work experience?

- **none**
- **1-5 years**
- **10- 20 years**
- **25-30**

What house are you assigned to?

- Long term Care
- Home Care
- Memory Care

What is your work shift?

- Day
- Evening
- Night

Clarke, Julia Aurora (2023)

Appendix M

Mindful Self-Care Scale -Brief

The Mindful Self-Care Scale- Brief is a 24-item scale that measures the self-reported frequency of behaviors that measure self-care behavior.

Self-care is defined as the daily process of being aware of and attending to one's basic physiological and emotional needs including the shaping of one's daily routine, relationships, and environment as needed to promote self-care. Mindful self-care addresses self-care and adds the component of mindful awareness.

Mindfulself-care is the foundational work required for physical and emotional well-being. Self-care is associated with positive physical health, emotional well-being, and mental health. Steady and intentional practice of mindful self-care is seen as protective by preventing the onset of mental healthsymptoms, job/school burnout, and improving work and school productivity.

This scale is intended to help individuals identify areas of strengthand weakness in mindful self-care behavior as well as assess interventions that serve to improve self-care. The scale addresses 6 domains of self-care: mindful relaxation,physical care, self-compassion and purpose, supportive relationships, supportive structure, and mindful awareness.

Contactinformation: CatherineCook-Cottone, Ph.D.at cpcook@buffalo.edu

Circle the number that reflects the frequency of your behavior(how much or how often) within past week (7days):

Never (0 days)	Rarely (1 day)	Sometimes (2 to 3 days)	Often (4 to 5 days)	Regularly (6 to 7 days)
1	2	3	4	5

Reverse-Scored:

Never (0 days)	Rarely (1 day)	Sometimes (2 to 3 days)	Often (4 to 5 days)	Regularly (6 to 7 days)
5	**4**	**3**	**2**	**1**

The questions on the scale follow.

Mindful Self-Care Scale – Brief

Mindful Relaxation (4 items)
I did something creative to relax (e.g., drew, played instrument, wrote creatively, sang, organized) 1 2 3 4 5
I listened to relax (e.g., to music, a podcast, radio show, rainforest sounds) 1 2 3 4 5
I sought out images to relax (e.g., art, film, window shopping, nature) 1 2 3 4 5
I sought out smells to relax (lotions, nature, candles/incense, smells of baking) 1 2 3 4 5
Total _____ Average for Subscale = Total/# of items _____

Physical Care (5 items)
I ate a variety of nutritious foods (e.g., vegetables, protein, fruits, and grains) 1 2 3 4 5 I exercised at least 30 to 60 minutes 1 2 3 4 5
I took part in sports, dance or other scheduled physical activities (e.g., sports teams, dance classes) 1 2 3 4 5
I did sedentary activities instead of exercising (e.g., watched tv, worked on the computer) *reverse scored* 5 4 3 2 1
I practiced yoga or another mind/body practice (e.g., Tae Kwon Do, Tai Chi) 1 2 3 4 5
Total _____ Average for Subscale = Total/# of items _____

Self-Compassion and Purpose (4 items)
I kindly acknowledged my own challenges and difficulties 1 2 3 4 5
I engaged in supportive and comforting self-talk (e.g., "My effort is valuable and meaningful") 1 2 3 4 5
I gave myself permission to feel my feelings (e.g., allowed myself to cry) 1 2 3 4 5
I experienced meaning and/or a larger purpose in my work/school life (e.g., for a cause) 1 2 3 4 5
Total _____ Average for Subscale = Total/# of items _____

Supportive Relationships (4 items)
I spent time with people who are good to me (e.g., support, encourage, and believe in me) 1 2 3 4 5
I felt supported by people in my life 1 2 3 4 5
I felt confident that people in my life would respect my choice if I said "no" 1 2 3 4 5
I felt that I had someone who would listen to me if I became upset (e.g., friend, counselor, group) 1 2 3 4 5
Total _____ Average for Subscale = Total/# of items _____

Supportive Structure (4 items)

I maintained a manageable schedule 1 2 3 4 5
I kept my work/schoolwork area organized to support my work/school tasks 1 2 3 4 5
I maintained balance between the demands of others and what is important to me 1 2 3 4 5
I maintained a comforting and pleasing living environment 1 2 3 4 5
Total _____ Average for Subscale = Total/# of items _____

Mindful Awareness (3 items)
I had a calm awareness of my thoughts 1 2 3 4 5
I had a calm awareness of my feelings 1 2 3 4 5
I had a calm awareness of my body 1 2 3 4 5
Total _____ Average for Subscale = Total/# of items _____

Total Score Summary
Be sure you have correctly scored your reversed-scored item
Averaged Score Subscale
_____ Mindful Relaxation
_____ Physical Care
_____ Self-Compassion and Purpose
_____ Supportive Relationships
_____ Supportive Structure
_____ Mindful Awareness

5						
4						
3						
2						
1						
Sca	Mindful Relaxation	Physical Care	Self-Compassion & Purpose	Supportive Relationships	Supportive Structure	Mindful Awareness

Shade in your average score for each subscale below:

For a long version of the scale and a detailed description of the source scale, see:
Cook-Cottone, C.P.(2015).*Mindfulness and yoga for embodied self-regulation: A primer for mental health professionals.* New York, NY: Springer Publishing.

Appendix N

Permission to use MSCS-Brief

rine Cook-Cottone

6, 2022, 6:58 PM (2 days ago)

Dear Julia

You have my permission to use (and translate is needed) the Mindful Self-Care Scale. You can find the three versions here
https://www.catherinecookcottone.com/research-and-teaching/mindful-self-care-scale/

In terms of research applications, the standard version is the one we recommend that you use in research (33 items). Or the 84 item scale for factor validation or factor analysis. Note, the subscales are not validated to be used independently. You do not have permission to use one or two scales or a variety of items. This would be a misrepresentation of our construct and would not be a valid assessment of mindful self-care or self-care.

You must describe the full construct of mindful self-care in your paper. Please read and cite as (this is open access and can be found on the journal's web page):

Cook-Cottone, C. P., & Guyker, W. M. (2018). The development and validation of the Mindful Self-Care Scale (MSCS): An assessment of practices that support positive embodiment. *Mindfulness*, *9*(1), 161-175.

For practical purposes, the 33 item scale can be used for a shorter check in or introduction to Mindful Self-Care. The 84 item scale is really good for working with programs, courses, and trainings and offers a much more in depth clinical view.

Automatic feedback- we also have a web page set up at the University at Buffalo that has a self-assessment with feedback here:
http://ed.buffalo.edu/mindful-assessment.html

If you are developing an application or other mechanism that will produce revenue, we require that you donate to www.yogisinservice.org a not-for-profit that the creators of the MSCS work with as a means of giving back, regularly, throughout the duration of your use of the scale. We also encourage you to reach out to us if you are able to help fund ongoing research of the scale.

Also please find our normative cutoffs attached.

Please keep us posted. Best of luck in your work!

Catherine

Catherine Cook-Cottone, PhD, RYT, C-IAYT (she/her)
Professor | Associate Dean of Academic Affairs, GSE
Licensed Psychologist | IATY Certified Yoga Therapist

Co-Editor in Chief, Eating Disorders: Journal of Treatment and Prevention
Director of the Mindful Counseling Advanced Certificate
Founder and President of Yogis in Service

Learn about Mindful Self-Care (MSC) here, take a MSC assessment here

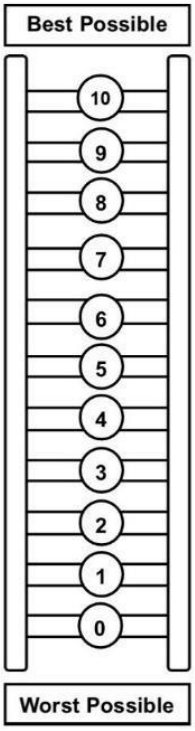
Recent Books:
Embodiment and the Treatment of Eating Disorders: The Body as a Resource in Recovery
Mindfulness and Yoga in Schools: A Guide for Teachers and Practitioners
Mindfulness and Yoga for Self-Regulation: A Primer for Mental Health Professionals
Mindfulness for Anxious Kids: A Workbook to Help Children Cope with Anxiety, Stress, and Worry"Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom." Viktor Frankl

Appendix O

Well-Being Assessment Survey

Well-being Assessment (Adult – 12 items) – 100 Million Healthier Lives

Please **circle the answer** that best represents your response to the questions below.



For the first three questions please imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the **best possible life for you** and the bottom of the ladder represents the **worst possible life for you.**

1. **On which step of the ladder would you say you personally feel you stand at this time?**

   Worst Best possible possible

   0 1 2 3 4 5 6 7 8 9 10

2. **On which step do you think you will stand about five years from now?**

   Worst Best possible possible

   0 1 2 3 4 5 6 7 8 9 10

3. **Now imagine the top of the ladder represents the best possible financial situation for you, and the bottom of the ladder represents the worst possible financial situation for you. Please indicate where on the ladder you stand right now.**

   Worst Best possible possible

   0 1 2 3 4 5 6 7 8 9 10

4. **In general, how would you rate your physical health?**

   Poor Excellent

0 1 2 3 4 5 6 7 8 9 10

5. **How would you rate your overall mental health?**

Poor Excellent

0 1 2 3 4 5 6 7 8 9 10

6. **For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do?**

Not limited Severely at all limited

0 1 2 3 4 5 6 7 8 9 10

7. **I have a sense of direction and purpose in life.**

Strongly Strongly disagree agree

0 1 2 3 4 5 6 7 8 9 10

How often do you feel lonely?

Never

Always

1 1 2 3 4 5 6 7 8 9 10

8. **How would you describe your sense of belonging to your local community?**

Very Very weak strong

0 1 2 3 4 5 6 7 8 9 10

9. **If you were in trouble, do you have relatives or friends you can count on to help you whenever you need them, or not?**

Never

Always

0 1 2 3 4 5 6 7 8 9 10

10. **During the past two weeks, how often have you experienced positive emotions such as joy, affection, or hope?**

Never

Always

0 1 2 3 4 5 6 7 8 9 10

11. **During the past two weeks, how often have you experienced negative emotions such as sadness, worry, or despair?**

Never

Always

0 1 2 3 4 5 6 7 8 9 10

Appendix P

IHI Well-Being Tool Permission

This is a human-readable summary of (and not a substitute for) the license. Disclaimer.

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Appendix Q

Table 1. Palouse MBSR Activity and Frequency Questionnaire

Activity	Time of day	Time spent on an activity	Frequency
▪ In which Mindfulness activities did you participate?	▪ What time of the day did you engage in Mindfulness activities?	▪ What was the average number of minutes you participated in a Mindfulness activity?	▪ How many times during the day did you participate in a Mindfulness activity?
Mindfulness breathing	Morning	2-10 minutes	1-2
Body scan	Afternoon	15-20 minutes	3-4
Walking meditation	Evening	25-30 minutes	5 or more
Loving-kindness	Night	More than 30 minutes	
Sitting meditation			
Silent meditation			

Clarke, Julia Aurora (2023)

Appendix R

Outcome Measures Table

Increase in the mean scores of Self-care behaviors in Unlicensed Assistive Personnel after the Mindfulness training.

Measure	**Measure Type***	**Data Source**	**Sampling Method**	**Timing/Frequency**
MSCS-B scores (adapted Cook-Cottone, C. P., & Guyker, W. M. (2018).	Outcome	MSCS-B scores	All participants' MSCB-B survey scores	MSCS-B will be administered prior to and after Mindfulness training.

Standard Measure?**	*Yes? https://www.catherinecookcottone.com/research-and-teaching/mindful-self-care-scale/#toggle-id-1*
Numerator	Mean participants' MSCS-B scores
Denominator or Population***	None
Exclusions	None
Calculation/Statistic(s)	Mean
Goal/Benchmark	Increase MSCS-B Mean score by 50% within 8 weeks for each category. *Mindfulness Relaxation*: min score 4, max 20; *Physical care*: min score 9, max 21 (reverse code); *Self-compassion and purpose*: min score 4, max score 20; *Supportive Relationships: min score 4, max score 20; Supportive structure: min score 4, max score 20; Mindful awareness: min score 3, max score 15.* Total min *score = 28;* Total max score *= 115*

Data Elements	**Variable Name**	**Definition**	**Data Type***	**Data Values & Coding**	**Restrictions/ Validation**
Mindful Relaxation	Creativity	I did something creative to relax (e.g., drew, played an instrument, wrote creatively, sang, organized).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Listen	I listen to relax (e.g., to music, a podcast, radio show, rainforest sounds)	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	

	Images	I sought out images to relax (e.g., art, film, window shopping, nature).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	

	Scents	I sought out smells to relax (lotions, nature, candles/incense, smells of baking).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
Physical Care	Food	I ate a variety of nutritious foods (e.g., vegetables, protein, fruits, and grains).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Exercise	I exercised at least 30-60 minutes	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Physical activity	I took part in sports, dance or other scheduled physical activities (e.g., sports teams, dance classes).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Sedentary activities	I did sedentary activities instead of exercising (e.g., watched tv, worked on the computer).	Categorical	**Never =5 Rarely + 2 Sometimes = 3 Often = 2 Regularly = 1	
	Mindful activities	I practiced yoga or another mind/body practice (e.g., Tae Kwon Do, Tai Chi).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
Self-Compression and purpose	Challenges and difficulties	I kindly acknowledge my own challenges and difficulties.	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4	

				Regularly = 5	
	Self-talk	I engaged in supportive and comforting self-talk (e.g., “My effort is valuable and meaningful”).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Feelings	I give myself permission to feel my feeings (e.g., allowed my self to cry).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Purpose	I experienced meaning and/or a larger purpose in my work/school life (e.g., for a cause).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
Supportive Relationships	Spent time	I spent time with people who are good to me (e.g., support, encourage, and believe in me).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Supported	I felt supported by people in my life.	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Confident	I felt confident that people in my life would respect my choice if I said n”o”	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Listened to	I felt that I had someone who would listen to me if I became upset (e.g., friend, counselor, group).	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
Supportive Structure	Schedule	I maintained a manageable schedule.	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	

	Organized	I kept my work/school area organized to support my work/school tasks	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Balance	I maintained balance between the demands of others and what is important to me,	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Comfort	I maintained a comforting and pleasing living environment.	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
Mindful Awareness	Thoughts	I had a calm awareness of my thoughts.	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Feelings	I had a calm awareness of my feelings.	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	
	Body	I had a calm awareness of my body	Categorical	Never = 1 Rarely = 2 Sometimes = 3 Often =4 Regularly = 5	

Increase in the Well-being assessment mean scores of UAP after Mindfulness training.

Well-being Assessment scores (survey adapted Stiefel MC, Riley, CL, Roy, B, Straszewski, T. (2020).	Outcome.	Well-being survey score.	All participants' Well-being survey scores.	Well-being survey will be administered before and after Mindfulness training,

Standard Measure?**	Yes- at www.ihi.org/100MLives.
Numerator	Mean participant Well-being assessment scores.
Denominator or Population***	None
Exclusions	None
Calculation/Statistic(s)	Mean
Goal/Benchmark	Increase in Well-being baseline score by 50 % within 8 weeks for each category. *Emotio*n: Min score 0, max 10; *Future*: min score 0, max score 10; *Financial:* min score 0, max 10; *Physical health*: min score 0, max score 10; *meant health*: min score 0; max score 10; *Limitation*: min score 0; max score 10 (reverse code); *Purpose:* min score 0, max score 10; *Lonely*: Min score 0, max score 10 (reverse code); *Sense of belonging*: min score 0, max score 10; Assistance: Min score 0, max score 10; *Positive emotions*: min score 0, max score 10; *Negative emotions*: min score 0, max score 10. Total min score= 20; Total max score = 100

Data Elements	**Variable Name**	**Definition**	**Data Type***	**Data Values & Coding**	**Restrictions/ Validation**
	Emotion	On which step of the ladder would you say you personally feel you stand at this time?	Categorical	10 = Best possible life for you. 9 8 7 6 5 4 3 2 1 0 = Worst possible life for you.	
	Future	On which step do you think you will stand about five years from now?	Categorical	10 = Best possible 9 8	

				7 6 5 4 3 2 1 0 = Worst possible	
	Financial	Now imagine the top of the ladder represents the best possible financial situation for you, and the bottom of the ladder represents the worst possible financial situation for you. Please indicate where on the ladder you stand right now.	Categorical	10 = Best possible 9 8 7 6 5 4 3 2 1 0 = Worst possible	
	Physical health	In general, how would you rate your physical health?	Categorical	10 = Excellent 9 8 7 6 5 4 3 2 1 0 = poor	

	Mental health	How would you rate your overall mental health?	Categorical	10 = Excellent 9 8	

				7 5 5 4 3 2 1 0 = Poor	
	Limitation	For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do?	Categorical	10 = Severely limited 9 8 7 6 5 4 3 2 1 0 = Not limited	
	Purpose	I have a sense of direction and purpose in life.	Categorical	10 =strongly agree 9 8 7 6 5 4 3 2 1 0 = Strongly disagree	
	Lonely	How often do you feel lonely?	Categorical	10 = Always 9 8 7 6 5 4 3 2	

				1 0 = Never	
	Sense of belonging	How would you describe your sense of belonging to your local community?	Categorical	10 = Strongly agree 9 8 7 6 5 4 3 2 1 0 =strongly disagree	
	Assistance	If you were in trouble, do you have relatives or friends you can count on to help you whenever you need them, or not?	Categorical	10 = Always 9 8 7 6 5 4 3 2 1 0 = Never	
	Positive emotions	During the past two weeks, how often you experience positive emotions such as joy, affection, or hope?	Categorical	10 = Always 9 8 7 6 5 4 3 2 1 0 = Never	
	Negative emotions	During the past two weeks, how often have you experienced negative emotions such as sadness, worry, or despair?	Categorical	10 = Always 9 8 7 6 5 4 3 2 1 0 = Never	

**Continuous, Categorical or Dichotomous*

Appendix S

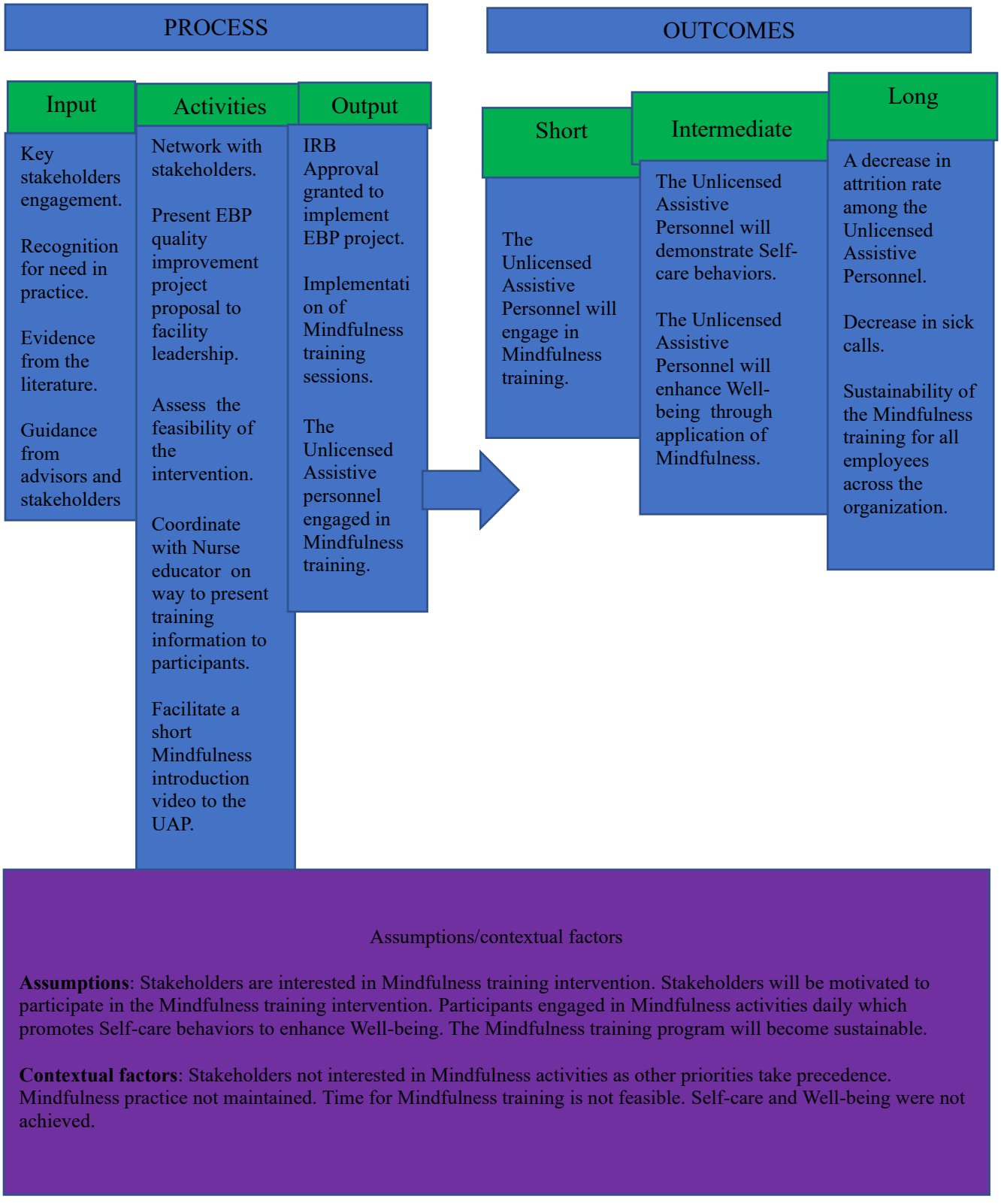
Gantt Chart

Project Activity	Timeline May 2023-April 2024											
Aim: To promote Self-care in the UAP through cultivating Mindfulness into daily practice to enhance Well-being.	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**April**
Obtain IRB approval from the practice site.				**X**								
Meet with Leadership and Stakeholders.		**X**			**X**	**X**						
Develop training lesson/modules.	**X**	**X**	**X**	**X**	**X**							
Administer pre-post-survey.						**X**	**X**	**X**				
Implement intervention.						**X**	**X**	**X**				
Collection of data						**X**	**X**	**X**	**X**			
Collaborate with a statistician on data input.								**X**	**X**	**X**	**X**	**X**
Analysis of data									**X**	**X**	**X**	**X**
Evaluation.									**X**	**X**	**X**	**X**
Dissemination of information.											**X**	**X**

Adapted from White et al. (2019).

Appendix T

Logic Model: Mindfulness



Appendix U

AIM & FIM Tool

Acceptability of Intervention Measure (AIM)

	Completely disagree	Disagree	Neither agree nor disagree	Agree	Completely agree
1.The Mindfulness Training meets my approval.	①	②	③	④	⑤
2.The Mindfulness Training is appealing to me.	①	②	③	④	⑤
3. I like The Mindfulness Training .	①	②	③	④	⑤

4. I welcome The Mindfulness Training .	①	②	③	④	⑤

Feasibility of Intervention Measure (FIM)

	Completely disagree	Disagree	Neither agree nor disagree	Agree	Completely agree
1. The Mindfulness training seems implementable.	①	②	③	④	⑤
2. The Mindfulness training seems possible.	①	②	③	④	⑤
3. The Mindfulness training seems doable.	①	②	③	④	⑤
4. The Mindfulness training seems easy to use.	①	②	③	④	⑤

Pragmatic Qualities:

- Readability tested by substituting “This EBP” for “Insert Intervention.” Flesch reading ease score (and grade level) is 95.15 (5th grade) for AIM, 99.60 (5th grade) for IAM, and 94.17 (5th grade) for FIM.
- No specialized training is needed to administer, score, or interpret the measures.
- Cut-off scores for interpretation not yet available; however, higher scores indicate greater acceptability, appropriateness, or feasibility.
- Norms not yet available.
- Scales can be created for each measure by averaging responses. Scale values range from 1 to 5. No items need to be reverse coded. Good measurement practice: assess structural validity to confirm the unidimensionality of each measure and calculate alpha coefficient to ascertain reliability.
- There is no cost to use these measures.
- Time to complete less than 5 minutes per measure.

Appendix V

Table 2

Demographics of project participants (n = 9)

Baseline characteristics	Frequency	%	m	sd
Age		100	41.56	13.685
20	1			
28	1			
31	1			
38	1			
42	1			
45	1			
54	1			
55	1			
61	1			
Gender			1.00	.000
Female	9	100		
Male	0			
Transgender	0			
Nonbinary	0			
Prefer not to identify	0			
Race/ethnicity				
Black	6	66.7		
Latinx	1	11.1		
White	1	11.1		
Asian	0			
Native American				
Other	1	11.1		
Immigrant				
Yes	2	22.2		
No	7	77.8		

Education level			2.33	.707
Some High School	1	11.1		
High School	4	44.4		
College/University	4	44.4		
Other	0			
Years of work experience				
None	0			
1-5 years	4	44.4		
10-20 years	5	55.6		
25-30 years	0			
House assigned (unit/dept).				
Long term care	**7**	77.8		
Home care	2	22.2		
Memory care	0			
Shift worked				
Day	4	44.4		
Evening	3	33.3		
Night	1	11.1		
Rotating shifts	1	11.1		

Table 3

Means for Pre and Post scores on MSCS-B and IHI-Well-being Assessment

Pre-intervention (n=)	M (SD)	Min	Max	Post-intervention (n=)	M (SD)	Min	Max
MSCS-B(n=8)	83.25 (17.351)	55	106	MSCSB(n=7)	88.57 (7.525)	80	98
Well-being (n=9)	54.56 (14.984)	27	83	Well-being (n = 7)	55.86 (8.133)	49	73

Table 4

Paired Samples t-Tests

		Mean	SD	Paired Difference	95%confidence interval of the difference		t	df	Significance	
				SD Error Mean	Lower	Upper			One-Sided	Two-sided
Pair 1	Pre-MSCS-B Post MSCS-B	-8.571	15.501	5.859	-22.908	5.765	-1.463	6	.097*	.194
Pair 2	Pre-Well being Post Well-being	1.571	15.393	5.818	-12.665	15.808	.270	6	.398	.796

*Note: *P-value <0 .1*

Appendix W

Figure 1. Pre-Post Mindfulness Training