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Evaluating the Effect of a Brief Mindfulness Intervention Designed to Reduce Compassion Fatigue
on Staff Mindfulness

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Nursing Practice
at the University of Kentucky

By

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Lexington, Kentucky

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Abstract

Background: Compassion fatigue is “stress resulting from exposure to a traumatized individual” and is described as “a state of physical and mental exhaustion caused by a depleted ability to cope with one’s everyday environment” (Cocker & Joss, 2016, p. 1). Fifty-two percent of mental health workers are experiencing compassion fatigue (The Mental Health of Healthcare Workers in COVID-19, 2020). Behavioral health units have some of the highest turnover rates across hundreds of hospital systems (2019 NSI National Health Care Retention & RN Staffing Report, 2019). Compassion fatigue has been identified as a risk factor for turnover in nurses and statistics display the need for evidence-based interventions such as mindfulness, a protective factor that may prevent turnover (Sung et al., 2012; Wells-English et al., 2019).

Purpose: The purpose of this DNP project is to evaluate the effectiveness of a web-based mindfulness intervention designed to reduce compassion fatigue and increase mindfulness in inpatient psychiatric staff.

Methods: A pretest-posttest quasi-experimental study will be used for this DNP project. Mindfulness will be measured pre-and-post intervention using the Mindfulness Attention Awareness Scale (MAAS). Paired t-tests will be used to analyze the differences in mindfulness before and after the intervention.

Results: Data analyses showed an increase in the total mindfulness using the MAAS survey. The score of the MAAS can range from a minimum score of 15 to a maximum score of 90. Using the MAAS, the higher the score, the more mindful a participant is and the lower the score the less mindful the participant is. The mean score pre-intervention was 65.1 and increased to 74.0 post-intervention; however, the increase in mindfulness post-intervention is not statistically significant with a p-value of .42.

Conclusions: Brief mindfulness interventions are an evidence-based approach to preventing and treating compassion fatigue. There is currently a gap in providing at-risk mental healthcare providers with ways to help prevent compassion fatigue, as over half experience compassion fatigue. This DNP project showed increased mindfulness, a protective factor for compassion fatigue, after implementing a brief mindfulness intervention. Although compassion fatigue could not be assessed due to facility project restrictions, these results do suggest that brief mindfulness interventions could help prevent compassion fatigue by promoting mindfulness, a protective factor.

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Background and Significance

Problem Statement

All caregivers working in healthcare are at risk for developing compassion fatigue; however, inpatient psychiatric staff members are at increased risk given the distress and trauma experienced by their patient population (Cutler et al., 2020). Compassion from healthcare workers provide psychiatric patients with a sense of security during their greatest time of need (Cutler et al., 2020). Compassion fatigue can cause psychiatric staff members to become unable to feel empathetic towards their patients, detached, and helpless (Harris & Griffin, 2015). When comparing specialties and their risk for compassion fatigue, nurses who work in psychiatric hospitals were extremely high-risk and more disposed to compassion fatigue compared to nurses in non-psychiatric settings (Jarrod et al., 2018). Given that psychiatric staff members are at high risk for compassion fatigue, the need for hospitals to have evidence-based interventions to promote protective factors and decrease risk factors for compassion fatigue is vital to the quality of psychiatric care provided.

Context, Scope, and Consequences of the Problem

It has been reported the in literature for decades that those who work with distressed patients are at risk of developing compassion fatigue (Figley, 1995). Compassion fatigue is an “empathic strain and general exhaustion” that results from caring for those who are distressed (Turgoose & Maddox, 2017, p. 172). This prolonged exposure to distressed patients creates exhaustion that decreases one’s ability to be empathetic (Elwood et al., 2011; Mathieu, 2007).

In 2019, Nursing Solutions, Inc (NSI) reported that of all nursing specialties, behavioral health reported the most turnover nationwide (2019). After analyzing previous years’ turnover rates, NSI found that every five years behavioral health units will turnover their whole staff of registered

nurses (2019 NSI National Health Care Retention & RN Staffing Report, 2019). The average cost of turnover for a Register Nurse is \$52,358 (2023 NSI National Health Care Retention & RN Staffing Report, 2023). In 2020, Mental Health America reported that 52% of mental health workers were experiencing compassion fatigue (“The Mental Health of Healthcare Workers in COVID-19”, 2020). Compassion fatigue has been identified in the literature as a risk factor for turnover and these statistics display the need for evidence-based interventions such as mindfulness that promote protective factors that may prevent turnover (Sung et al., 2012; Wells-English et al., 2019).

Compassion fatigue has several risk and protective factors that have been identified. Risk factors include high case load, being of female gender, personal trauma, maladaptive coping skills, and personal psychological stress (“The Mental Health of Healthcare Workers in COVID-19”, 2020; Turgoose & Maddox, 2017; Glover-Stief et al., 2020). Protective factors include mindfulness practices, good coping strategies, active participation in one’s religion, and support from friends and family (Glover-Stief et al., 2020; Turgoose & Maddox, 2017).

Compassion fatigue can cause “organizational symptoms”, such as, “high absenteeism, constant changes in coworkers’ relationships, inability for teams to work together, desire among staff members to break company rules, outbreaks of aggressive behaviors among staff, inability of staff to complete assignments and tasks, inability of staff to respect and meet deadlines, negativism toward management, strong reluctance toward change, inability of staff to believe improvement is possible, and lack of a vision for the future” (Lee et al., 2019, p. 771). Additionally, compassion fatigue increases turnover rates and disability leaves (Lee et al., 2019). The costs of turnover per nurse “ranges from \$37,700 to \$58,400” and continues to rise (Lee et al., 2019, p.771).

Compassion fatigue not only affects the person mentally and physically, but it also affects their ability to provide quality patient care (APNA, 2012; Aiken et al., 2002; Hanrahan et al., 2010).

Current Evidence-Based Interventions

The following strategies are used in the literature to promote protective factors and reduce risk factors of compassion fatigue: mindfulness-based interventions, self-care activities and education on compassion fatigue (Adimando, 2018; Conversano, 2020; Fortney et al., 2013). Mindfulness-based interventions, implementation of self-care activities, and education all reduce risk for compassion fatigue; however, there is more specific research on structured mindfulness program success at reducing compassion fatigue and preventing compassion fatigue. Mindfulness-Based Stress Reduction (MBSR) is a structured 8-week in-person or livestreamed program started by Dr. Jon Kabat-Zinn at the University of Massachusetts over 35 years ago (“Center for Mindfulness”). The program helps participants alter their relationship with stress using mindfulness meditation in the form of exercise, daily homework, and guided practice (“Center for Mindfulness”). It has been reported in the literature that brief versions of MBSR have provided nurses with coping mechanisms to help treat compassion fatigue (Duarte & Pinto-Gouveia, 2016; Owens et al., 2020). Mindfulness-based interventions among healthcare staff reduce risk factors for and promote protective factors for compassion fatigue (Janssen et al., 2018; Ghawadra et al., 2019).

Purpose and Objectives

The purpose of this DNP project was to evaluate the effectiveness of a web-based mindfulness training intervention in promoting protective factors for compassion fatigue in psychiatric staff members on a psychiatric inpatient unit. The problem was addressed by implementing a brief mindfulness intervention inspired by the evidence based MBSR program. Prior to the intervention, mindfulness was assessed using the Mindful Attention Awareness Scale (MAAS). Participants were also asked to fill out a demographics survey. The intervention consisted of an educational video on breathing techniques that would be used in their

daily mindfulness practices. The participants were given two mindfulness practices on video, body scanning and guided imagery, and asked to practice one of their choosing every day for 30 days. At the end of the 30 days, the participants were asked to retake the MAAS.

The specific aim of this project was to determine the impact of a brief web-based MBSR inspired mindfulness program designed to reduced compassion fatigue on mindfulness among inpatient psychiatric staff members.

Review of Literature

The literature reports that mindfulness is a modifiable protective factor in preventing compassion fatigue (Turgoose & Maddox, 2017; Wylde et al., 2017). A review of strategies for implementing Mindfulness Based Stress Reduction (MBSR) into clinical practice provided important guidance for this project. The question guiding the review is: Among inpatient psychiatric staff members, how has MBSR affected mindfulness and compassion fatigue?

The search began by using population, outcome, and intervention of this literature review's question as key terms. The terms include: "mindfulness intervention" AND "compassion fatigue," "psychiatric nurses" AND "MBSR", and "Brief mindfulness intervention" AND "nurses." No MeSH search terms were used. The following databases were searched: Pubmed, CINAHL, Cochrane Database, and EBSOHOST. One hundred and fifty-seven articles were returned, and five articles were selected with the inclusion criteria of healthcare providers as the population and exclusion criteria of publication greater than 10 years.

Synthesis of Evidence

Two systematic reviews were found that consisted of a total of 33 studies. The populations included mental health professionals at medical facilities within the United States, Canada, Japan,

Malaysia, Portugal, and Brazil. The studies within the systematic reviews consisted of the following: randomized control trials, quasi experimental, and one-group pre-posttest designs (Janssen et al., 2018; Ghawadra et al., 2019). Additionally, three individual studies were found that were set in the United States and Portugal. These studies consisted of the following: a two-group pretest-posttest design (Wylde et al., 2017), a pretest-posttest non-randomized study (Duarte & Pinto-Gouveia, 2016), and a pretest-posttest exploratory study (Owens et al., 2020).

MBSR is a program that consistently improves mindfulness, a protective factor in preventing compassion fatigue, when measured post intervention (Janssen et al., 2018; Ghawadra et al., 2019). A systematic review reported that out of 14 MBSR programs, modified and traditional, that evaluated mindfulness pre-and-post intervention, 12 studies reported a significant increase in mindfulness in the treatment groups (Janssen et al., 2018). This systematic review also reported that due to the varying lengths of modified and traditional MBSR programs in the review, effect of program lengths cannot be stated or concluded and needs to be further researched in the future (Janssen et al., 2018). The research for abbreviated MBSR varies and is limited when looking at online verses in person programs. Wylde et al. (2017) reported that nurses who completed a mindfulness intervention online did show a “significantly greater increase on some facets of mindfulness”, including “acting with awareness” and “non-reactivity of inner experience”, when compared to the traditional face-to-face group (Wylde et al., 2017, p. 210). The most used components in abbreviated MBSR programs include the following: breathing techniques, body scanning, and meditation and relaxation exercises such as guided imagery (Ghawadra et al., 2019; Janssen et al., 2018).

A significant decrease was seen in compassion fatigue after brief mindfulness interventions (Duarte & Pinto-Gouveia, 2016; Owens et al., 2020). Additionally, Wylde et al. (2017) saw an

increase in compassion satisfaction after a brief MBSR inspired mindfulness intervention. It was also found that online interventions showed more compassion satisfaction and less risk for compassion fatigue post intervention compared to in-person mindfulness interventions (Wylde et al., 2017).

The conclusion of the systematic reviews shows that MBSR increases mindfulness (Janssen et al., 2018; Ghawadra et al., 2019). Although the research is limited, in studies that measured compassion fatigue after a brief mindfulness intervention, a reduction was seen (Duarte & Pinto-Gouveia, 2016; Owens et al., 2020).

Gaps in Practice

More than half of mental health providers are experiencing compassion fatigue (“The Mental Health of Healthcare Workers in COVID-19”, 2020). Every five years behavioral health units turnover their entire nursing staff (NSI, 2019). There is great need for further education and resources geared towards prevention and treatment of compassion fatigue for nursing staff (Peters, 2018). This DNP project addressed this gap by implementing an abbreviated MBSR program on an inpatient psychiatric unit. An abbreviated MBSR program was chosen as the intervention due to its evidence in reducing compassion fatigue and improving mindfulness.

Theoretical/Conceptual Framework or Model

The Public Health Model is used in a variety of settings including healthcare and focuses on prevention and reduction of risk by distinguishing risk factors (“Defining the Public Health Model for the Child Welfare Services Context”, 2014). The Public Health Model provided a framework for this DNP project and involved defining the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption (Centers for Disease

Control and Prevention, 2021). The problem with compassion fatigue was identified through personal experience of the primary investigator as an inpatient psychiatric nurse and reviewing the literature. The risk and protective factors for preventing compassion fatigue and strengthening compassion satisfaction that are mentioned above were identified in the literature. As discussed previously, brief MBSR inspired mindfulness interventions were identified in the literature to strengthen coping mechanisms, such as mindfulness, and reduce compassion fatigue (Duarte & Pinto-Gouveia, 2016; Owens et al., 2020). The intervention was developed by a certified MBSR instructor. Widespread adoption of the intervention is encouraged to all psychiatric inpatient settings within the DNP project implementation site.

Methods

Design

This DNP project used a quasi-experimental, one group pretest-posttest design to examine the effect of a brief web-based mindfulness intervention among inpatient psychiatric staff members. The project aimed to help psychiatric staff members develop a better understanding of mindfulness practices, improve mindfulness, and reduce compassion fatigue.

Setting

Project Congruence

The project took place at Norton Hospital's inpatient adult psychiatric unit in Louisville, Kentucky. This is a 21-bed inpatient facility. Norton Healthcare's mission is to "provide quality care to all those [they] serve, in a manner that responds to the need of [their] communities and honors [their] faith" ("About Us: Norton Healthcare Louisville, KY," 2022). This project's ability to improve mindfulness among psychiatric staff members may better aid them to provide even

greater quality of care to their patients and the community, which is the sole mission of Norton Healthcare. This project aligns with the Norton Healthcare's mission of providing quality care because the purpose of this project was to provide staff members with ways to improve their coping skills, such as mindfulness, to help address compassion fatigue among the psychiatric staff.

Description of Stakeholders

The primary stakeholders in the project were employees and patients, as compassion fatigue affects the staff's ability to work as a team in providing the patients with quality care. Amber Smith, the unit manager at the start of the project, agreed to support the project's implementation and was a stakeholder in this project as compassion fatigue can affect her staff's ability to perform to their best ability, potentially affecting patient and employee satisfaction. The quality director, Dr. Nena Hoenck, DNP, and the Director of the Center for Academic and Scholarly Affairs, Dr. Michelle Pendleton, DNP, served as mentors for the project at Norton Hospital. The DNP committee consisting of Dr. Holly Gray, Dr. Lee Ann Walmsley, and Dr. Andrew Makowski were also key stakeholders.

Facilitators and Barriers

The facility's staff and administration were the facilitators for this DNP project. Norton Hospital inpatient psychiatric unit has therapists, chaplains, and staff members that currently strive to have a work environment that supports new ideas to better help the unit and patients. Some staff members acted as facilitators for the project by encouraging others to participate. Additionally, Norton Healthcare's Quality Director acted as a facilitator due to her support and belief in the use of mindfulness techniques to help staff with various challenges. A barrier was time commitment and length of the project for already busy staff members. The use of technology and simplification of the project helped make the project more feasible.

Sample

The target population for this project were all inpatient adult psychiatric staff members involved with patient care, including floor nurses, behavioral health associates, chaplains, therapists, and nurse managers. The project excluded all staff members who are not directly caring for patients on the psychiatric unit. Additionally, this study excluded all those who do not work for Norton Healthcare, including University of Louisville medical residents and doctors. All members in the project sample had to be over the age of 18. The sample of this study was a convenience sample.

Procedure

IRB Approval

Norton Healthcare's IRB approval process started with concept approval from the Director of Scholarly and Academic affairs, the Quality Director, Chief Nursing Officer and the unit manager where the project took place. After concept approval, the final proposal was submitted to Norton Healthcare Operational and Human Resources and Norton Healthcare Research Office for approval. After Norton Healthcare's IRB submission process was completed, the project was approved through University of Kentucky's IRB submission process.

Description of Evidence-based Intervention

The participants were recruited via email. The email sent to employees included all instructions to participate in the project and the consent cover letter. The PI visited the unit periodically during the two-week pre-intervention data collection period to explain the project in person during the unit's shift change meetings and passed out research packets to all staff at the meeting. The research packets included project instructions, video links for the mindfulness intervention, consent cover letter, and all pretest and posttest surveys.

The web-based mindfulness intervention is a brief mindfulness-based intervention inspired by the well-known Mindfulness Based Stress Reduction (MBSR) program created by Dr. Jon Kabat Zinn (“Center for Mindfulness”). Videos were used to facilitate daily body scanning and guided imagery. The brief MBSR inspired mindfulness intervention was created by Dr. Lee Ann Walmsley, a certified MBSR instructor. Dr. Walmsley incorporated mindfulness practices that were most used in the literature where compassion fatigue was reduced and mindfulness was increased (Ghawadra et al., 2019; Janssen et al., 2018). The staff members received an educational video on breathing techniques to watch once to help participants learn the fundamentals of deep breathing prior to starting the 30 days of mindful practice. After watching the one-time educational video on deep breathing, participants were asked to watch one of the mindful practice videos of their choosing, with a goal to watch one every day for 30 days, guiding them through body scanning or guided imagery.

After the 30-day intervention, a two-week post-intervention data collection period was completed. The PI visited the unit periodically during the two-week post-intervention data collection period during the unit’s shift change meetings to remind participants to submit their post-intervention surveys. All pre-and-post intervention surveys were submitted by the participant to a locked drop-box in the report room.

Measurements and Instruments

The following demographics were assessed with a questionnaire to evaluate the sample: gender, age, profession, years of experience, and race. Mindfulness was measured pre-and-post intervention using the Mindful Attention Awareness Scale (MAAS) (Brown & Ryan, 2003). The MAAS questionnaire has been validated using various types of patient samples (Brown & Ryan, 2003). The MAAS is 15 questions using a 1-6 Likert scale. The higher one’s MAAS score is, the

more mindful the person. Post-intervention participants were asked to complete the Video Frequency Survey. This survey was created by the PI to evaluate how many times participants watched the videos each week.

Data Collection

Demographic information was measured using a paper survey pre-intervention. Mindfulness was measured pre-and-post intervention with the printed version of the MAAS tool. The frequency of the videos watched of each participant in the study was measured post-intervention using a paper version of the Video Frequency Survey. Pre-intervention data collection started on December 25th, 2022 and ended on January 7th, 2022. An initial email was sent to the unit at the beginning of pre-intervention data collection inviting them to participate in the study and instructions on how to participate. Post-intervention data collection started on February 7th, 2022 and ended on February 18th, 2022. A reminder email was sent to participants at the beginning of the post-intervention data collection period to remind participants to submit post-intervention surveys. During each data collection period, the PI periodically checked in with the staff during shift starter meeting. Surveys were not linked to any individuals and did not contain any identifiers. Completed questionnaires were placed into a locked drop box on the unit by the participant.

Data Analyses

Collected data was transferred from paper surveys to an excel sheet, then transferred for analysis to IBM SPSS, version 29. Frequency distributions were used to display demographic data and the Post-Intervention Video Frequency survey results. Two sample t-tests were used to analyze the differences in total mindfulness before and after the intervention. It was planned that cases with missing data would be omitted from analyses, but all surveys were fully completed.

Results

The inpatient psychiatric unit has fifty-two employees who were invited to participate in the study. A total of nine participants enrolled in the study by completing the pre-intervention surveys. Of those nine enrolled, three completed the post-intervention surveys.

Of the nine who completed the pre-surveys, all were female (100%; see Table 1). Two Behavioral Health Associates (22.2%), one Therapist/Chaplain (11.1%), and six registered nurses being the majority of those to enroll at 66.7%. Two of those enrolled have less than one year experience in the profession (22.2 %), one participant has six to ten years of experience (11.1%), two participants have over twenty-one years of experience (22.2%), and majority of the participants, four total, have one to five years of experience (44.4%). The ages are well distributed; however, the majority are between the ages of 30-39 (33.3%). Majority of the participants were white at 88.9% of those enrolled with one black or African American participant (11.1%).

Data analyses shows an increase in the total mindfulness using the MAAS survey as shown in Table 2. The score of the MAAS can range from a minimum score of 15 to a maximum score of 90. Using the MAAS, the higher the score, the more mindful a participant is and the lower the score the less mindful the participant is. The mean score pre-intervention was 65.1 and increased to 74.0 post-intervention; however, the increase in mindfulness post-intervention is not statistically significant with a p-value of .42, as shown in Table 2. The Post-Intervention Video Frequency survey showed that 100% of the three participants that finished the study watched 1-2 videos per week for four weeks (see Table 3).

Discussion

Findings as it Relates to the Existing Literature

There are many strategies in the literature created to promote protective factors and reduce risk factors of compassion fatigue, however, there is more specific research on structured mindfulness program success at reducing and preventing compassion fatigue. There are several studies showing that brief mindfulness interventions increase mindfulness and decrease compassion fatigue. Although administration at Norton did not allow compassion fatigue to be measured, an increase in mindfulness was found. Mindfulness is a modifiable protective factor for compassion fatigue. Our results do align with current research solely measuring mindfulness pre-and-post intervention; however, this project was unable to measure compassion fatigue, making the project unable to determine a change in compassion fatigue post-intervention.

Project Impact & Sustainability Plans

This DNP project found there was an impact on the staff's mindfulness. The project found there was an increase in mindfulness post-brief mindfulness intervention, however, the increase in staff mindfulness was not statistically significant. This project is unable to show the impact of this intervention on compassion fatigue due to study restrictions from Human Resources at the facility. The staff have been encouraged to continue mindful practices of their liking moving forward to help maintain results and potentially prevent compassion fatigue in the future. PI plans to share results with PI once new management has been finalized on unit. PI also plans to find a facility in the future to launch this project with the inclusion of measuring compassion fatigue pre-and-post intervention. PI is also considering launching this project in other at-risk specialty areas, such as, step-down units, emergency departments, and intensive care units. Mindfulness is a relatively new

concept in the literature. This is the beginning of mindfulness being utilized in literature to solve long-standing problems in healthcare.

Implications

Practice Implications for Practice, Education, Policy, and Research

This DNP project, along with other literature, shows that brief mindfulness interventions can increase mindfulness, a protective factor for compassion fatigue. Having evidence-based interventions for staff could help improve mindfulness and prevent and treat compassion fatigue. The mindfulness intervention for this project was simple, easy to follow, and easily accessible online to practice anywhere. Psychiatric staff members should be educated on ways to lower their risk for compassion fatigue such as improving mindfulness. Staff should be further educated on what mindfulness is, why it is important, and how they can engage in ways to improve mindfulness and prevent compassion fatigue. Brief mindfulness interventions provide staff with ways to better cope with stress and alter their relationship with it to lower their risk for compassion fatigue. Mental health workers need to be educated by hospitals of their increased risk for compassion fatigue. Mental health workers should be educated on the risk and protective factors of compassion fatigue to help decrease risk.

Although this project showed that a brief mindfulness intervention can improve mindfulness, the sample size was small. There is a need for more research to be conducted on a larger scale. There is also a need for research to be conducted on mindfulness scores long term post-intervention. Majority of the current research only tests mindfulness and compassion fatigue immediately after the intervention. This project is unable to show the impact of this intervention on compassion fatigue due to study restrictions from Human Resources at the facility. There is a need for further research on how mindfulness directly impacts compassion fatigue in psychiatric staff

members to better understand how to improve compassion fatigue in a population at great risk for it. No policy recommendations came from this DNP project.

Limitations

This DNP project had three primary restrictions: Human Resources study restrictions, unexpected change in leadership, and increased unit acuity during pre-intervention data collection. During project approval HR had restrictions to the types of data the PI could collect. Another unexpected limitation was the unexpected change in management during the project. Changes in leadership may have affected participation. The unit acuity during the pre-intervention data collection period was high and likely affected participation. These limitations may have contributed to the small sample size and impacted the statistical results of the DNP project.

Conclusion

Compassion fatigue is an “empathic strain and general exhaustion” that results from caring for those who are distressed (Turgoose & Maddox, 2017, p. 172). Compassion fatigue affects over half of mental health professionals (“The Mental Health of Healthcare Workers in COVID-19”, 2020). Compassion fatigue has several risk and protective factors that have been identified. Mindfulness was chosen as the modifiable protective factor to improve with a goal of preventing and treating compassion fatigue.

This DNP project aimed to improve mindfulness, a protective factor for compassion fatigue, using a brief mindfulness intervention designed to reduce compassion fatigue. There are many interventions in literature that help reduce and prevention compassion fatigue, however, there is more research on structured mindfulness programs’ effect on mindfulness and compassion fatigue. An evidence-based intervention was created using aspects of Mindfulness Based Stress Reduction

(MBSR) and created by a MBSR instructor. This web-based intervention asked participants to watch one mindful practice video daily for 30 days. Mindfulness was measured pre-and-post intervention using the MAAS. It was found that mindfulness slightly increased post-intervention. The project proves that mindfulness does improve using brief mindfulness interventions, however, the increase in mindfulness was not statistically significant. This improvement in mindfulness could help reduce staff's risk for compassion fatigue. The more hospitals invest in interventions to prevent compassion fatigue, the less compassion fatigue will be seen in at-risk staff members.

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Tables

Table 1. Descriptive Summary of Demographic Information (N=9).

	<i>n (%)</i>
Gender	
Female	9 (100%)
Male	0 (0%)
Profession	
RN	6 (66.7%)
BHA	2 (22.2%)
Therapist/Chaplain	1 (11.1%)
Years of Experience	
<1 year	2 (22.2%)
1-5 years	4 (44.4%)
6-10 years	1 (11.1%)
11-20 years	0 (0%)
21+ years	2 (22.2%)
Age	
18-29	1 (11.1%)
30-39	3 (33.3%)
40-49	2 (22.2%)
50-59	2 (22.2%)
60-69	1 (11.1%)
70-79	0 (0%)
80-89	0 (0%)
Race	
White	8 (88.9)
Hispanic, Latino, or Spanish origin	0 (0%)
Black or AA	1 (11.1%)
Asian	0 (0%)
American Indian or Alaska Native	0 (0%)
Middle Eastern or North African	0 (0%)
Native Hawaiian or other pacific islander	0 (0%)
Some other race, ethnicity, or origin	0 (0%)

Abbreviations: AA= African American, RN= Registered Nurse, BHA= Behavioral Health Associate

Table 2. Total Mindfulness Score Pre- and Post-Intervention.

	Pre-Intervention (<i>n</i> = 9)	Post-Intervention (<i>n</i> = 3)	<i>p</i>
Total mindfulness score (Potential range 15-90)	65.1 (17.0)	74.0 (10.8)	.42

Table 3. Video Frequency Survey.

	Post-Intervention (<i>n</i> = 3)
Number of Videos per Week	
Every day	3 (100%)
3-6 times a week	0 (0%)
1-3 times a week	0 (0%)

Appendices

Appendix A: Mindfulness Attention Awareness Scale (MAAS)

Day-to-Day Experiences

Instructions: Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each item separately from every other item.

1	2	3	4	5	6
Almost Always	Very Frequently	Somewhat Frequently	Somewhat Infrequently	Very Infrequently	Almost Never

I could be experiencing some emotion and not be conscious of it until some time later.	1	2	3	4	5	6
I break or spill things because of carelessness, not paying attention, or thinking of something else.	1	2	3	4	5	6
I find it difficult to stay focused on what's happening in the present.	1	2	3	4	5	6
I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.	1	2	3	4	5	6
I tend not to notice feelings of physical tension or discomfort until they really grab my attention.	1	2	3	4	5	6
I forget a person's name almost as soon as I've been told it for the first time.	1	2	3	4	5	6
It seems I am "running on automatic," without much awareness of what I'm doing.	1	2	3	4	5	6
I rush through activities without being really attentive to them.	1	2	3	4	5	6
I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.	1	2	3	4	5	6
I do jobs or tasks automatically, without being aware of what I'm doing.	1	2	3	4	5	6
I find myself listening to someone with one ear, doing something else at the same time.	1	2	3	4	5	6

1	2	3	4	5	6
Almost	Very	Somewhat	Somewhat	Very	Almost
Always	Frequently	Frequently	Infrequently	Infrequently	Never

I drive places on 'automatic pilot' and then wonder why I went there.	1	2	3	4	5	6
I find myself preoccupied with the future or the past.	1	2	3	4	5	6
I find myself doing things without paying attention.	1	2	3	4	5	6
I snack without being aware that I'm eating.	1	2	3	4	5	6

Appendix B: Demographics Survey

1. Gender:

- a. Male
- b. Female
- c. Transgender male
- d. Transgender female
- e. Prefer not to answer

2. Profession

- a. Registered nurse (RN)
- b. Licensed Practical Nurse (LPN)
- c. Behavioral health associate (BHA)
- d. Therapist/Chaplain

3. Number of years in profession

- a. Less than a year
- b. 1-5 years
- c. 5-10 years
- d. 10-20 years
- e. 30 + years

4. Age

- a. 18-29
- b. 30-39
- c. 40-49
- d. 50-59
- e. 60-69
- f. 70-79
- g. 79-89

5. Race

- a. White
- b. Hispanic, Latino, or Spanish origin
- c. Black or African American
- d. Asian
- e. American Indian or Alaska Native
- f. Middle Eastern or North African
- g. Native Hawaiian or other pacific islander
- h. Some other race, ethnicity, or origin

Appendix C: Consent Cover Letter

To Participant:

Researchers at the University of Kentucky are inviting you to take part in a research study involving the impact of a brief mindfulness intervention that has been designed to reduced compassion fatigue on levels of mindfulness. The mindfulness intervention includes a short introduction video to teach participants how to deep breathe, which is a skill that will be used during the mindfulness practices the participants choose from each day. Participant will choose between two videos walking you through two mindful practices: body scanning and guided imagery. The participant is to watch one of the two videos every day for 1 month. Participants can pick and choose whichever mindfulness practice they wish each day, for example, a participant can watch the video practicing body scanning every day for the whole month or they could switch up their practice/video each day.

The pre-post surveys include demographic items, questions assessing mindfulness, and questions evaluating the number of times one viewed the videos. Your survey responses will not be linked to you and are anonymous. The pre-survey will be administered over an estimated 2-week period, prior to the 30-day intervention. The post-intervention survey will be administered over an estimated 2-week period after the 30-day intervention. The pre-post surveys will take about 15 minutes to complete and can be turned in to the locked drop box in the nurses station once completed.

Although you may not get personal benefit from taking part in this research study, your responses may help us understand more about the impact of brief mindfulness practices on overall mindfulness. Some volunteers experience satisfaction from knowing they have contributed to research that may possibly benefit others in the future.

Your identity will be protected due to the fact that your responses to the surveys are anonymous which means no names, IP addresses, email addresses, or any other identifiable information will be collected with the survey responses. We will not know which responses are yours if you choose to participate.

Although we have tried to minimize this, some questions may make you upset or feel uncomfortable and you may choose not to answer them. If some questions do upset you, we can tell you about some people who may be able to help you with these feelings. Additionally, some of the videos/mindful practices may make you upset or feel uncomfortable and you may choose to stop at any point in time without penalization.

We hoping to get a 70% response rate from participants. Of course, you have a choice about whether or not to complete the survey/questionnaire, but if you do participate, you are free to skip any questions or discontinue at any time. You will not be penalized in any way for skipping or discontinuing the survey.

Participants have the right to not participate in the study by not submitting surveys. If you do not want to be in the study, there are no other choices except not to take part in the study.

Those who choose to participate in the study can complete the daily study activities while working. On participant's days off, study activities can be done on the participant's own time.

Thank you in advance for your assistance with this important project.

If you have questions about the study, please feel free to ask; my contact information is given below.

My research is being guided by Dr. Holly Gray DNP, APRN, PMHNP-BC. Contact information below.

If you have complaints, suggestions, or questions about your rights as a research volunteer, contact the staff in the University of Kentucky Office of Research Integrity at 859-257-9428 or toll-free at 1-866- 400-9428.

Sincerely,
Catherine Siegel BSN, RN
Psychiatric DNP Student, University of Kentucky
PHONE: 502-619-0830
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Holly Gray, DNP, APRN, PMHNP-BC
Assistant Professor University of Kentucky College of Nursing
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Appendix D: Post-Intervention Video Frequency Survey

How often did I watch the mindfulness videos?

- a. I watched one video each day for 30 days.
- b. I watched one video each day 3-6 times each week.
- c. I watched one video each day 1-2 times each week.