A Mindfulness and Health Promotion Program to Decrease The Perception of Stress and Burnout in Psychiatric Mental Health Nurses Who Provide Direct Patient Care To Individuals in Mental Health Units With A Diagnosis of Alzheimer's Type Dementia

LaTarsha Waltronia Bilal Edwards
The University of Southern Mississippi

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A MINDFULNESS AND HEALTH PROMOTION PROGRAM TO DECREASE
THE PERCEPTION OF STRESS AND BURNOUT IN PSYCHIATRIC
MENTAL HEALTH NURSES WHO PROVIDE DIRECT PATIENT
CARE TO INDIVIDUALS IN MENTAL HEALTH UNITS WITH
A DIAGNOSIS OF ALZHEIMER’S TYPE DEMENTIA

by

LaTarsha Waltronia Bilal Edwards

Abstract of a Capstone Project
Submitted to the Graduate School
Of The University of Southern Mississippi
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Nursing Practice

August 2015
ABSTRACT

A MINDFULNESS AND HEALTH PROMOTION PROGRAM TO DECREASE THE PERCEPTION OF STRESS AND BURNOUT IN PSYCHIATRIC MENTAL HEALTH NURSES WHO PROVIDE DIRECT PATIENT CARE TO INDIVIDUALS IN MENTAL HEALTH UNITS WITH A DIAGNOSIS OF ALZHEIMER’S TYPE DEMENTIA

by LaTarsha Waltronia Bilal Edwards

August 2015

The principle of this systems-change project is to employ a stress management and health promotion program in Alzheimer’s type units to decrease the perception of stress and burnout in psychiatric-mental health nurses providing direct care in secured units. This systems-change project will implement mindfulness techniques as an effective tool for reducing the perception of stress and burnout.

The mindfulness-based stress reduction and burnout prevention program will be implemented into staff development programs for nurses working in locked and psychiatric units in the community. Mindfulness-based stress reduction is an operational tool to aid nurses psychologically and to increase work satisfaction.

Behavioral and psychological symptoms of dementia often lead to admission into long-term care facilities or to nursing home placement. High levels of stress and burnout are a significant problem for registered nurses (RNs) in long-term care. RNs providing care to this population are at increased risk for elevated levels of stress and burnout.
The Use of the Mindfulness Based Stress Reduction Program as an intervention will show if it is effective in decreasing the perception of stress and burnout in psychiatric nurses who work in Alzheimer’s type dementia units.
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Approved:

_____________________________________
Dr. Rowena Elliott, Committee Chair
Associate Professor, Advanced Practice

_____________________________________
Dr. M. Janie Butts, Committee Member
Professor, Systems Leadership and Health Outcomes

_____________________________________
Dr. Karen S. Coats
Dean of the Graduate School

August 2015
ACKNOWLEDGMENTS

I would like to acknowledge Dr. Rowena Elliott, Dr. Anita Boykin, Dr. Janie Butts, and Mrs. Sonia Adams for their persistence and dedication throughout this process.

May this work help my fellow nurses provide quality of care. May it also be an inspiration to my children and nurses to come.
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CHAPTER I

INTRODUCTION

Nursing is a profession that looks at individuals holistically. As caregivers, nurses must care for themselves in order to give fully to those they serve. Unmanaged stress can adversely affect the caring process. Nurses are leaving the profession due to reporting feelings of exhaustion and the inability to deliver quality of care to the patients. Management of stress is a tool that is invaluable to the profession of nursing.

“Work-related stress is a widespread problem and has shown to be costly to both individuals and organizations” (Stanks, 2005). A review of literature identified that occupational stress cost U.S. economy $300 billion a year (Werner & DeSimone, 2009, as cited in Moheyddeen, 2012). Associated private dysfunction includes somatic exhaustion, sleeplessness, drug and alcohol addictions, and personal conflicts (Baba, Galperin, & Lituchy, 1999; Farrington, 1995). Larger company expenses has increased truancy, lateness, employee hiring and firing rate, low confidence, decreased efficiency and job fulfillment, and legal reimbursement (Firth & Britton, 1989; Wheeler & Riding, 1994). Analyses have confirmed the view of burnout can put at risk the specialist’s aptitude to deliver superior nursing support and quality of care to the clients (Coffey, 1999; Fagin, Carson, Leary, de Villiers, Bartlett, O’Malley, & Brown, 1996; Jenkins & Elliott, 2004; Kilfedder, Power, & Wells, 2001).

According to AbuAlRub (2004), Balevre (2001), and Hall (2004), studies have shown that the nursing occupation is highly stressful. When a nurse encounters strain for an extended period of time in amalgamation without unsuccessful coping, it can also develop into burnout (Maslach & Leiter, 1997). Burnout results in emotional exhaustion,
reduced efficacy, and lower feelings of accomplishment (George, 2005). According to Maslach, Jackson, and Leiter (1996), burnout is “a syndrome of emotional exhaustion, depersonalization, and reduction of personal accomplishment that can occur among individuals who work with people in some capacity” (p. 1). However, George (2005) reported that as use of positive coping mechanisms increased, feelings of depression and anxiety decreased, and an increase in productive work was seen. Implementation of mindfulness-based stress reduction (MBSR) interventions will improve positive coping mechanisms, decrease the perception of stress and burnout, and improve superiority of care and excellence of lifecycle for dementia patients in locked units. MBSR interventions are effective in decreasing anxiety and encouraging peace and harmony in medical and non-medical environments (Cohen-Katz, Wiley, Capuano, Baker, Kimmel, & Shapiro, 2005; Gold, Smith, Hopper, Herne, Tansey, & Hulland, 2010; Penque, 2009; Shapiro, Astin, Bishop, & Cordova, 2005). Mindfulness stress reduction training includes implementing the aptitude to remain conscious of one’s present views, feelings, physical perceptions, and compassionate and empathetic. Mindfulness stress reduction may increase client care throughout client protection, fulfillment, and excellence of results.

Mindfulness-Based Stress Reduction Program

Mindfulness-based stress reduction (MBSR) is a wellness program that includes class education and exercises of mindfulness methods, thought, and Hatha yoga intended to encourage somatic and emotional well-being (Kabat-Zinn, 1990). The MBSR program lasts two weeks and is instructed for 3 hours a work week (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004). The effectiveness of the MBSR program is supported in the literature for stress reduction.
The MBSR program’s advantages have been recorded in investigative analyses for clients and include reduction in nervousness, pain, and hopelessness as well as enhanced medical treatment and interventions (Epstein, 2003; Gross, Kreitzer, Russas, Treesak, Frazier, & Hertz, 2004; Kabat-Zinn, Massion, Kristeller, Peterson, Fletcher, Pbert, Lenderking, & Santorelli, 1992).

MBSR is a tool that can assist psychiatric RNs caring for patients with Alzheimer’s type dementia in managing the perception of work stress and improving patient outcomes. Less than a twelve analysis have been led on the usage of MBSR by healthcare specialists, and only two trials have focused exclusively on nurses and nursing assistants (Cohen-Katz et al., 2004; Mackenzie, Poulin, & Seidman-Carlson, 2006). Further studies are needed to narrow the gap in knowledge in the research of the MBSR program and its implementation for psychiatric nurses who work in Alzheimer’s type dementia locked units.

Purpose of the Program

The objective of this systems-change project is towards implement a stress management and health promotion program using mindfulness interventions to decrease the perception of occupational anxiety and exhaustion in psychiatric nurses who provide direct care in psychiatric units to patients with Alzheimer’s type dementia. Improving coping skills of RNs providing this type of care will reduce the perception occupational stress and burnout. Placing a mindfulness-based stress reduction program and health promotion program in psychiatric Alzheimer’s type dementia units would be a good systems change in practice to decrease the perception of occupational stress and burnout in psychiatric nurses. This data will propose a clinical change practice initiative. I will
recommend this program during an orientation for nursing caregivers and will present it yearly through the educational development program in nursing homes and hospitals to improve the emotional state of nursing caregivers and thereby increase the quality of care and patient outcomes in psychiatric units.

According to the PICOT question format, the nurses will be the population of this program; the implementation of a mindfulness program will be the intervention; not implementing a mindfulness program will represent the comparison; and the decrease in the perception of stress and burnout will be the outcome over a two-week period of time, which will be the program’s time frame.

Needs Assessment

This program will provide a method of decreasing the perception of stress and burnout, specifically in nurses who work in psychiatric dementia-type units, to better understand nurses and formulate better polices and guidelines to meet their needs in stress reduction. The outcomes will improve the present form of information relevant towards anxiety, managing, and exhaustion suffered by nurses who are employed in psychiatric care. The conclusions can furthermore deliver these caregivers thru an improved comprehension of the perception of work-related stressors, burnout, and positive coping mechanisms. These data will propose a clinical change practice initiative. I will implement a clinical change initiative through the staff development educational program in nursing homes and hospitals to improve the emotional well-being of caregivers thus increasing the excellence of care and improving patient outcomes.
Statement of the Problem

Psychiatric-mental health nurses employed in inaccessible units deliver assiduousness aimed at patient residents that necessitates enlarged surveillance in addition to intricate management modalities. This discloses psychiatric care givers to a diversity of problematic and exclusive industrial stressors. Research has confirmed that nursing care givers employed in other parts of psychiatry experience a momentous altitude of anxiety. This program will examine the perception of stress and burnout in psychiatric nurses who work in locked units, their coping strategies, and the efficiency of a mindfulness-based intervention program to decrease the perception of stress in RNs working in Alzheimer’s type dementia units.

The researcher will address the following PICOT question in the program:

1. Will implementing a mindfulness-based stress reduction and well-being promotion intervention administered over a two week period decrease the perception of stress and burnout of psychiatric nurses who care for patients with Alzheimer’s type dementia compared to those who do not use this program.

Alzheimer’s Type Dementia and Characteristics of the Disease Process

Dementia is a degenerative brain-based disease that is chronic and progresses into cognitive decline. Cognitive decline is a disorder in which a person requires a difficulty with remembrance, linguistic, or alternative necessary mental task; serious enough to be obvious to others plus demonstrate on test (Alzheimer’s Association, 2007). Alzheimer’s remains the largest type of dementia, and is a degeneration process that progresses through three stages: early, middle, and late. In early Alzheimer’s, a cognitive decline is
seen in memory but does not affect activities of daily living (Alzheimer’s Association, 2007). In early stages, clear symptoms include forgetfulness in numerous parts such as amnesia of recent events and diminished skill to achieve stimulating psychological tasks, aimed at, for instance, calculating numbers from 100 backwards and subtracting in seven sequences. Other symptoms include larger struggle executing multifaceted jobs, such as preparing dinner for guests, disbursing payments or handling funds, and amnesia about one’s individual private history. Such patients also become temperamental or introverted, particularly in social or intellectually stimulating circumstances.

In moderate Alzheimer’s type dementia over an eight-to-ten-year span, a gradual increase in functional dependence and loss of capacity to achieve aspects of existence, such as shopping, and managing financial responsibilities, and driving, occur (Alzheimer’s Association, 2007). Breaches in commemoration and reasoning are noticeable, and persons initiate to require aid with everyday performances. Some symptoms of the middle stage of Alzheimer’s type dementia include existence of being unable to recall individual address or telephone number or the names of the high school or university from which the person graduated. In the middle stage of the disease, the person becomes more disorganized about anywhere he or she is or what time it is and requires assistance selecting appropriate dress for the time of year, or the event. The person is able recall important details about themselves and their relatives and does not require aid with consumption of food or using the lavatory (Alzheimer’s Association, 2012).

Eventually, in the late stages of Alzheimer’s type dementia, grooming, toileting, dressing, and eating become impaired (Alzheimer’s Association, 2007). The person loses
mindfulness of latest events as well as of his or her environments; the person remembers his or her own name but has difficulty with personal history. In the later stages of this disease process, the person is unable to differentiate recognizable and unrecognizable faces and has distress regurgitating the name of a spouse or caregiver. The person will require assistance putting on clothes, shoes, and assistance with activities of daily living. In late-stage dementia, the patient may encounter major character and social changes, encompassing suspiciousness and false impression (such as believing the caregiver is an imposter or someone else) (Alzheimer’s Association, 2012).

In the final, or end, stage of the illness, persons might not be competent to express words, toilet themselves, or help with their day-to-day individual maintenance, including consumption. They lose the aptitude to reply to their environmental setting or to carry on a dialogue; at this stage the dementia type patients lose the ability to ambulate and control muscle reflexes; swallowing also becomes impaired (Alzheimer’s Association, 2012).

Dementia frequency rises significantly as we grow older. The occurrence of Alzheimer’s type dementia is 3–11% in individuals older than 65 and 25–47% in people older than 85 (USPSTF, 2003). As the disease progresses, professional nursing staff are needed to provide care for those affected with dementia. Alzheimer’s Association (2007) projected that the number of those afflicted with Alzheimer’s type dementia (which is the largest form of dementia) would increase from 454,000 new cases a year by 2010 (Alzheimer’s Association, 2010) to 615,000 new cases a year by 2030 and to 959,000 new cases a year by 2050. The increasing prevalence of dementia and the related surge in dementia-related health care costs have encouraged a plea for nurses and continuing care
facilities. There remains a necessity aimed at cost-effective interventions to increase nurses’ skills and to provide safe, quality care to patients with Alzheimer’s type dementia in long-term settings.

In long-term care facilities, nurses play a prominent role in caregiving by performing assessment, administering medication, and documenting the patient’s response to medication. The need for continuous care services rises if an individual cannot achieve activities such as dressing, showering, and grocery shopping, and handling currency. According to Alzheimer’s Association (2013), state and federal Medicaid spending for nursing home care for people with Alzheimer’s and other dementias was estimated to be $142 billion in 2013. It further estimated that “federal and state government governments combined will spend $35 billion under the Medicaid program in 2013. Government spending represents 70 percent of the total costs of caring for those with Alzheimer’s.” Alzheimer’s Association (2013) further estimated that in 2050, “Medicare will spend a projected $627 billion caring for people with Alzheimer’s disease—an increase of nearly 600 percent between 2010 and 2050.” Finally, Alzheimer’s Association (2013) projected that “Medicaid spending on people with Alzheimer’s will increase nearly 400 percent between 2010 and 2050, as cost will reach $178 billion in 2050.”

According to a study conducted by Kennedy (2005), registered nurses had more anxiety and burnout than any other level of nursing profession; but all nursing staff levels, while performing job duties, showed substantial association amongst stress and insufficient training to meet the psychological requirements of the clients.
If stress is not managed, it may lead to occupational burnout. Occupational burnout refers to the process of emotional exhaustion, decreased or reduced efficacy, and negative attitudes towards work and environment. Professional nurses being subjected to extraordinary altitudes of burnout frequently plan to depart their present employments or the nursing profession completely (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004).

Exhaustion and burnout has developed into a prevalent research subject in health and wellness due to its impact on nurse preservation and turnover as well as patient outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). It has become imperative to implement ways of assisting nurses maintain positive coping skills due to the emotional demands of caring for patients. Studies have shown that implementing positive coping mechanisms forms a barrier against emotional distress, and that nursing caregivers are more likely to use positive coping mechanisms, especially in long term care settings (Evers, Tomic, & Brouwers, 2002).

It has been shown in studies that clients of health care professionals suffering from anxiety and burnout suffer extensively subordinate altitudes of fulfillment with their care (Vahey et al., 2004). Psychiatric nurses are principally susceptible due to an absence of public support, decrease employee levels, humiliation and stigma associated with caring for the mentally ill, and patient pressures involving the threat of violence. The frequency of exhaustion and burnout among psychiatric nurses has extended up to 59.2%; therefore, it is essential to implement a program to decrease stress and burnout in psychiatric nurses (Imai, Nakao, Tsuchiya, Kuroda, & Katoh, 2004). Exhaustion and burnout produces momentous complications related towards the care delivery in psychological health care locales since nurses agonize from burnout might develop
negative behavior, elude admiration or interest on behalf of their patients, and become
dehumanized to their patients’ needs (Berling, 2001). In addition, the growing number of
psychiatric patients related to the declining quantity of bed availability and competent
mental health nursing staff requires that the psychiatric nurses spend less time taking care
of patients consequently delivering a lower level of quality of care to the patient (De
Carlo, 2013).

Therefore, implementing a mindfulness-based stress reduction and health
promotion program to RNs taking care of Alzheimer’s type dementia patients is
imperative in order to assure high excellence of care for patients in nursing homes and
other long term care facilities. It is possible through evidence-based practice interventions
that have the potential to improve service provision.

The purpose of this mindfulness-based stress reduction and health promotion
program is to decrease stress and burnout in psychiatric nurses who care for Alzheimer’s
type dementia patients. The implementation of this program will increase excellence of
provision of care and excellence of lifecycle for Alzheimer’s type dementia patients.
Decreasing stress will improve the caring process that is given by RNs. This program will
improve the health care delivery system of this population.

According to Jalowiec, Murphy, and Powers (1984), applying the conceptual
framework of adaptation to nursing encourages and allows examination of the dynamic
interface between person and environment. The rationale for this project, a literature
analysis exploring the concepts of coping, burnout, long-term care, and occupational
stress was conducted. Little research had been done regarding RNs and certified nursing
assistants who work with dementia patients in long-term care and experience burnout.
Nevertheless, psychiatric staffing employees represent one of the groups of healthcare workers that represent the highest risk of burnout (Thomsen, Soares, Nolan, Dallender, & Arnetz, 1999). Exhaustion and burnout remains a serious problem for psychiatric health care provisions by mean of leading to the reduced efficiency of the employees and inferior management of patient outcomes (Priebe, Fakhoury, White, Watts, Bebbington, Billings, & Pan-London Assertive Outreach Study Group, 2004).

Standards of Care

It is recommended to target assessment for dementia when a patient exhibits decline in self-regulating living and protection related using recall or thought alterations, symptoms of mild intellectual deficiency, knowledge incapacities, and neurological conditions such as, stroke and Parkinson’s disease (Alzheimer’s Association, 2012). Simple engagements of living such as showering, putting on clothes, combing and brushing hair, and ambulating to the toilet, should be assessed (Alzheimer’s Association, 2012).

Tools for Early Identification of Dementia

Cognition assessment tools that have been validated to use for assessing cognition function include the Mini-Cognition assessment tool, Mini-Mental State Examination (MMSE), Montreal Cognitive Assessment (MoCA), and General Practitioner Assessment of Cognition (GPCOG) (USPSTF, 2003). The Mini-Cognition tool takes approximately two to four minutes to administer. A score lower 3 is indicative of dementia and directs the necessity for further dementia examination (USPSTF, 2003). MMSE is one of the most widely used tests and has high specificity (USPSTF, 2003). This test takes eight minutes to administer. When implementing the MMSE a total lesser than 24 is indicative
of dementia or delirium (USPSTF, 2003). MoCA is the most comprehensive test and has high sensitivity. This test takes approximately 10 minutes to administer, and a total lesser than 26 is indicative of dementia or mild intellectual impairment (USPSTF, 2003).

**Diagnosis**

It is imperative to do a thorough assessment to rule out other cause of cognitive impairment before a diagnosis of dementia is made. “Assessment includes a detailed history taking, cognitive and mental state examination, physical examination, and a review of medications” (Alzheimer’s Association, 2012). There remains no positive data to endorse or contradict ordering regular laboratory analyses such as a comprehensive plasma count, electrolytes, glucose, and renal and liver function tests. A diagnostic conclusion of dementia cannot be finalized completely founded on the results of any of the cognitive assessment tools and involves that efficient status correlate well with the outcomes (USPSTF, 2003). Tables 1 and 2 present symptoms and criteria for diagnosing dementia. Table 3 outlines major points of delivering the diagnosis.

**Table 1**

*Diagnosing Dementia Using DSM-IV Criteria*

<table>
<thead>
<tr>
<th>Dementia Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Memory impairment</td>
</tr>
<tr>
<td>2. At least one of the following:</td>
</tr>
<tr>
<td>a. Aphasia—inaibility to use and understand language;</td>
</tr>
<tr>
<td>b. Apraxia—inaibility to perform learned movement;</td>
</tr>
<tr>
<td>c. Agnosia—inaibility to recognize objects;</td>
</tr>
<tr>
<td>d. Disturbance in executive functioning;</td>
</tr>
<tr>
<td>e. Cognitive deficits significantly interfering with work, social activities, or relationships; and</td>
</tr>
<tr>
<td>f. Cognitive deficits not occurring exclusively during delirium.</td>
</tr>
</tbody>
</table>

*Note.* See American Psychiatric Association (2013).
Table 2

*Additional Criteria for Determining Dementia Type* ¹

<table>
<thead>
<tr>
<th>Dementia Type</th>
<th>Prevalence ²</th>
<th>Common Signs/Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>50%</td>
<td>Gradual onset with continuing decline; Social withdrawal; Paranoia; Anxiety not caused by identifiable medical, psychiatric, or neuralgic condition.</td>
</tr>
<tr>
<td>Vascular dementia</td>
<td>About 25%</td>
<td>Focal neurological signs or laboratory evidence of cerebrovascular condition (white-matter changes on imaging [although many patients with Alzheimer’s disease also have such changes]; In general, a more stepwise decline compared to a more gradual decline of patients with Alzheimer’s.</td>
</tr>
<tr>
<td>Lewy bodies dementia</td>
<td>15%</td>
<td>History of fluctuating cognitive performance; Well-formed visual hallucinations (unrelated to dopaminergic therapy); History of parkinsonism emerging simultaneously with cognitive impairment; Parkinson’s associated dementia is characterized by onset of Parkinson’s disease symptoms before dementia onset.</td>
</tr>
<tr>
<td>Dementia due to other causes</td>
<td>5%</td>
<td>Evidence from history, physical exam or laboratory findings of a specific medical condition causing cognitive deficits (head trauma, HIV disease, Parkinson’s disease, Huntington’s chorea, Pick’s disease, Creutzfeldt-Jakob disease). ⁴ ⁵</td>
</tr>
</tbody>
</table>

Note. ¹Adapted from American Psychiatric Association. ²See Burns & Iliffe (2009). ³Includes mixed-cause cases (vascular and Alzheimer’s dementias). ⁴There is no clear data to support or refute ordering routine laboratory studies such as complete blood count, electrolytes, glucose, and renal and liver function tests. ⁵There is no evidence for routine use of genetic markers. False positives may occur and would be emotionally and financially devastating.
Table 3

Delivering a Diagnosis of Dementia

<table>
<thead>
<tr>
<th>Key considerations</th>
<th>Talking points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Explain the biology of the disease and what to expect;</td>
<td>A. “Memory changes are due to abnormal accumulation of proteins in the brain, which interferes with the essential functions of thinking processing. Basically, these proteins clog things up”;</td>
</tr>
<tr>
<td>B. Maintain independence as much as possible; and</td>
<td>B. “Eventually, dementia will cause a worsening in your ability to handle regular tasks, such as shopping, finances, and taking medications. But we'll talk regularly, and we'll manage that”;</td>
</tr>
<tr>
<td>C. Create a safe environment.</td>
<td>C. “Dementia is not hereditary in most cases”;</td>
</tr>
<tr>
<td></td>
<td>D. “Dementia is a progressive condition with no cure, but we have treatments for symptoms. And proper care and planning can greatly alleviate the burden of dementia”; and</td>
</tr>
<tr>
<td></td>
<td>E. “It is important for you and your family to plan for the future, and it is especially important for you to make legal plans. The sooner legal planning starts, the more you may be able to participate. Legal planning includes advance directives.”</td>
</tr>
</tbody>
</table>

Treatment and Care Plan

Family should be included in the treatment plan and goals. From the assessment and treatment plan the type of support needed for the patient and caregiver will be based on the progression of the disease. It is imperative to educate the family that disease will impose deficits in memory, functioning of daily living, behavior, and mood (National Institute for Health and Clinical Excellence, 2011). Lifestyle modification and non-pharmacologic options, such as exercise and implementing patient centered hobbies, can
decrease behavioral disturbances and increase mood and effect. Day treatment programs and occupational therapy programs also improve quality of life for dementia patients (Alzheimer’s Association, 2012).

The treatment plan may include the use of medications. It is important for nurses to educate the patients and family members that the medication slows the disease process of cognitive decline but does not cure the disease (Sobow & Kloszewska, 2007). When the treatment plan includes using medications, functional and behavioral goals should be developed in care plan meetings with the patient, caregivers and family to help maintain finances of the checkbook, maintain a prescribed medication schedule, and increase social interaction (Boudreau, Yu, Gray, Raebel, Johnson, & Larson, 2011). A plan of care should be created to monitor the medication’s safety and effectiveness. Medication should be continued only as long as the patient’s global functioning and behavioral conditions remain at a level where the drug is considered having a worthwhile effect (Diniz, Pinto, Gonzaga, Guimarães, Gattaz, & Forlenza, 2009). Table 4 presents the goals of dementia treatment.

Table 4

*Treatment Goals for Dementia*

<table>
<thead>
<tr>
<th>Dementia Disease Stages</th>
<th>Treatment Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild cognitive impairment/ memory loss</td>
<td>• Maintain function, safety, and independence;</td>
</tr>
<tr>
<td></td>
<td>• Reduce or cease medication that may be contributing to decreased cognition.</td>
</tr>
<tr>
<td>Early-stage dementia</td>
<td>• Maintain function and independence while preserving safety;</td>
</tr>
<tr>
<td></td>
<td>• Reduce or cease medication that may be contributing to decreased cognition.</td>
</tr>
</tbody>
</table>
Table 4 (continued).

*Treatment Goals for Dementia*

<table>
<thead>
<tr>
<th>Dementia Disease Stages</th>
<th>Treatment Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mid-stage dementia</strong></td>
<td>• Preserve safety, function, and independence;</td>
</tr>
<tr>
<td></td>
<td>• Develop skills that support continued living at home and delay institutionalization;</td>
</tr>
<tr>
<td><strong>Late-stage dementia</strong></td>
<td>• Preserve safety, comfort, and dignity;</td>
</tr>
<tr>
<td><strong>End-stage dementia</strong></td>
<td>• Consider hospice referral.</td>
</tr>
</tbody>
</table>

*Care Facilities for Alzheimer’s Type Dementia Patients*

Alzheimer’s is a progressive cognitive decline of the thought processes and physical decline of functional ability to care for oneself. The somatic and psychological stressors on the family may become too exacting and overwhelming (Russell, de Benedictis, & Saisan, 2014). It is imperative the family is educated that when the patient progress to the late-stage dementia process will require total assistance with bathing, dressing, and toileting and 24 hour supervision (Russell et al., 2014).

Two types of facilities care for Alzheimer’s type dementia patients: assisted living facilities and nursing homes with locked units. Assisted living remains a choice used for families who require assistance with approximately actions of everyday living. Staff is available 24 hours a day, and some facilities provide minor help with medication as well (Russell et al., 2014). Nursing homes with special care units for Alzheimer’s patients should provide assistance in both activities of daily living and a high level of medical care (Russell et al., 2014). A medical director oversees the care provided at nursing homes where skilled nursing professionals specializing in psychiatric dementia care.
provide 24-hour care for patients (Russell et al., 2014). Alzheimer’s units should have policy and procedures for caring for dementia type patients. There should be dedicated staffing according to patient acuity (Russell et al., 2014). Activities should be patient specific and should be implemented daily according to the patients’ needs. Training and education in Alzheimer’s type units should be planned monthly.

*Psychiatric-Mental Health Nurses’ Roles and Responsibilities*

Psychiatric unit nurses are RNs specializing in the institutional care of large hospitals and medical centers that have patients staying in the unit for a short-term evaluation or at intensive treatment centers or in long-term care units (Nurses for a Healthier Tomorrow, 2014).

Psychiatric nurses work with patients with various mental and behavioral conditions that require them to focus on patient interaction. Psychiatric mental health nurses care aimed at clients with a disease process that has led them to momentary or continuing hospitalization or psychiatric Alzheimer’s units (Nurses for a Healthier Tomorrow, 2014). Psychiatric unit nurses are assigned to provide direct care to their patients, including facilitating social and emotional needs, supervising medication scheduling, and evaluating patient progress. Psychiatric nurses provide the best possible care by collaborating with a variety of interdisciplinary professionals (Nurses for a Healthier Tomorrow, 2014). Registered nurses (RNs) are also responsible for educating the patient’s family about the patient’s conditions and creating a supportive environment for the patient in long-term care, which is very important.

Psychiatric nurses are responsible for maintaining a safe environment with observing devices and restrictive methods when required. They encourage community
cooperation by generating and fostering clients to participate in support groups, social activities, and therapeutically redirecting patients in a calm manner when needed.

Psychiatric nurses are the primary resources of psychiatric patient care and community.

Psychiatric mental health nurses are accountable for the day to day care and activities of patients, promoting recovery through community collaboration and traditional medical process and procedure modalities.

**Definition of Terms**

1. **Burnout**—“a key aspect of the burnout syndrome is increased feelings of emotional exhaustion” (Maslach et al., 1996). Burnout is also characterized by depersonalization (also referred to as “cynicism”) and decrease in personal accomplishment (Maslach, 1982). Assignment includes bodily and psychological loads as well as the variety of employment and services required.

   Workplace stress is the physical and emotional outcomes of a discrepancy amongst difficulties of the occupation and the total of management the person has in meeting the demands of the job. (Lambert & Lambert, 2008). As McShane and Von Glinow (2005) stated, if stress is not managed, it leads to burnout. The cumulative result of stress leads to burnout, the process by which emotional exhaustion, cynicism and reduced efficacy occurs. For example, staff turnover sick days and angry outbursts are associated with burnout. Employees may become unhappy and dissatisfied with their accomplishments on the job. Employees’ lack of influence on decisions that affect their job may cause burnout—for example, employee’s inability to control the flow of work, the hours of work, assignments and unclear job expectations (Mayo Clinic, n.d.).
2. *Coping*—“a vital part of any person’s survival in today’s fast-paced health care environment.” (Lazarus and Folkman, 1984). Lazarus and Folkman (1984) noted that “coping serves two overriding functions: managing or altering the problem with the environment causing distress (problem-focused coping) and regulating the emotional response to the problem (emotion-focused coping)” (p. 179). Lazarus defined coping as “not a single act but a constellation of many acts and thoughts engendered by a complex set of demands that may stretch out over time” (1998, p. 207). The election of coping decision is established by inner and outward influences. Individual itinerary (e.g., opinions, morals, knowledge) and assets (e.g., monetary or community sponsorship) effect the results.

Coping activities are usually categorized as problem-oriented tactics and affective-oriented (temporary) techniques. The problem-oriented tactics are those applied to resolve stress-producing complications, while the affective-oriented techniques operate the emotional piece encompassed. Temporary coping methods (ingestion of food, napping, and smoking) help discharge professionals’ feeling that their deeds are not creating optimistic outcomes (Maslach, 1982). Such temporary approaches decrease strain momentarily however, it does not resolve directly with the worrying situation. Extracting on earlier occurrences and communicating with others are illustrations of enduring stress-reduction tactics as well. The problem-oriented procedures, however, are seen as positive ways of managing stress (Keller, 1990).
3. *Mindfulness*—to be aware of the present, in the moment and being aware. Mindfulness is a non-judgmental method of existence. To become mindful, a person can attain it through practice, mentoring and education.

Conceptual and Operational Definition of Terms

1. *Stress*—conceptually defined as the somatic, biological, and psychological process that generates anxiety and can produce sickness. Anxiety and stress can be observed as either helpful or adverse, even though anxiety and stress is usually reflected undesirable. According to Maslach and Jackson (1981), many events can cause bad stress for some individuals and positive stress for others. Not all individuals exhibit stress the same way. Operationally, stress will be defined by responses to the MBI-Human Services Survey that will be implemented in this study to measure perceptions of anxiety and stress. The assessment instrument is a 22-item questionnaire. The MBI scale measures answers correlated to actions undergone at work by the psychiatric nurse such as dealing with emotionally and unstable patients, having an absence of vitality or feeling drained daily, having to deal with coworkers who do not do their portion of the labor, and emotions of frustrations of the job.

2. *Coping*—a distinctive established thoughts and actions that are activated by startling proceedings or extreme stresses (stressors). The coping plan used by the persons differs and is governed by a diversity of reasons. Operationally, coping will be defined by responses to the MBI Questionnaire (McElfatrick, Carson, Annett, Cooper, Holloway, & Kuipers, 2000) that will be used in this analysis to gauge
the level to which numerous managing approaches will be utilized by psychiatric
nurses who deal with occupational stressors.

3. **Burnout**—a somatic, psychological, and emotional reaction to continuous ex-
traordinary levels of worry and unsuccessful or insufficient managing methods
(Maslach & Jackson, 1981). Burnout yields an alteration of moods and actions in-
cluding ineptness, helplessness, scorn, bitterness, unproductivity, and decreased
efficiency (Maslach & Jackson, 1981). Operational meaning of burnout will be
provided by responses to the MBI-Human Services Survey (MBI-HSS) (Maslach
& Jackson, 1981) that will be applied in this program to calculate the occurrence
of burnout. The MBI-HSS consists of 22 declarations asking the participants to
rate his or her thoughts concerning a diversity of conditions. An example of the
statements is “Professionals feel that their actions are not producing positive re-
results” (Maslach, 1982).

Clinical Practice of Nurses and Burnout

*The Work Environment*

It is estimated approximately 500,000 RNs in the United States are not in the
nursing profession due to the difficult working conditions, limited employees, and long
hours (Herbst, 2007). Nurses make critical decisions that may result in moral distress and
virtuous stress, which can lead to momentous physical magnitudes. A statistical analysis
discovered that 15% of nurses reported leaving their positions because of moral distress
in the workplace (Corley, Elswick, Gorman, & Clor, 2001). Due to understaffing of
qualified nurses, nurses are caring for more patients each shift, which has decreased the
quality of care for the patients and increased emotional and moral distress for the nurses.
as well. Understaffing contributed to nearly a quarter of the unanticipated problems that result in death or injury to hospital patients (Joint Commission on Accreditation of Healthcare Organizations, 2002).

The U.S. Bureau of Labor Statistics and U.S. Department of Labor (n.d.) reported that overexertion resulted in 39% of RN injuries. Nurses working overtime, twelve to sixteen hour shifts compromise the nurses’ cardiovascular health. In their analysis, Virtanen, Ferrie, Singh-Manoux, Shipley, Vahtera, Marmot, and Kivimäki (2010) analyzed and showed a link between nurses’ who worked frequent overtime had higher incidences of heart disease; nurses who reported working three to four hours overtime per day were 1.6 times more likely to develop cardiovascular disease.

Many nurses are complaining of heavy workloads which are causing burnout. Irritability, insomnia, headache, weight gain, high blood pressure and depression are some symptoms of chronic fatigue (Malugani, 2009). Approximately forty-nine percent of RNs under 30 and over 40 experienced high levels of burnout (Grove & Erickson, 2006). A study by Aiken, Clarke, & Sloane (2002) showed that when a registered nurse has over four patients, the threat of demise for infirmary clients increases by 7%.

While the American economy declined in 2009, the U.S. Bureau of Labor Statistics, U.S. Department of Labor (n.d.) estimated the nursing occupation will develop to be the number one occupation in relations of progression. Escalation in expansion is mainly owed to the extraordinary staff resignation rate, opportunity rates, increasing amount of retiring baby-boomer age generation nurses, and inflamed wellness requirements of clients. The existing nationwide opening rate in the occupation of registered nursing is 8.1% and the mandate remnants to carry on by about 2% each year
(AACN, 2014). These figures are astounding to the American community and are considered a health care emergency for superiority and safety of the clients we care for (Cost of Poor Quality, 2008).

Nurses and Burnout

Studies have identified and reported by nurse’s that heavy levels of work acquired by inadequate staffing is the most common cause of stress and burnout (Joint Commission, 2012). The Maslach Burnout Inventory (MBI) survey has been used in studies, analysis have shown a correlation between inadequate staffing and a high score on the Emotional Exhaustion subscale (Aiken, Clark, & Sloane, 2002; GAO, 2001; Vahey et al., 2004). Other factors related to increased workload include, on-call shifts, mandatory overtime, extended shifts, high patient volume, and consecutive shifts for extended periods of time. Increased levels of patient needs also contribute to work overload. A high level of care with short stays, unbalanced workload with inconsistency of acuity of care, and nursing shortage are sources of burnout in nursing staff (Maslach, 2003; Vahey et al., 2004). Decrease in retention of nurses is highly related to the nursing shortage because of stress and emotional exhaustion. Job dissatisfaction increases with inadequate staffing, which leads to burnout, nursing turnover, and decreased staffing-nurse to patient ratios (ANA, 2010). Projection of the nursing shortage is estimated to be more than 250,000 by 2025 (Buerhaus, Auerbach, & Staiger, 2009), which will increase burnout in the working population of nurses.

Further, research studies deliberate important stress nurses feel when caring for patients in infirmary settings (Cronqvist, Theorell, Burns, & Lützén, 2001). The definite exertion of loving and caring for the client and family needs could create happiness
however while caring for patients it subject’s nurses to occupational stress. Patient care can be multifaceted and challenging. According to Shimizu, Mizoue, Kubota, Mishima, and Nagata (2003), nurses remain at significant hazard for occupational stress. Providing care for some categories of clients that are terminally ill, in continuing discomfort, psychiatric patients, and patients who are expiring can be difficult and challenging. Nurses who work in these areas are at high risk for burnout. If stress is not handled successfully, it can lead to job discontent and potential health complications for nurses.

*Patient Outcomes*

Several studies have shown that decreased staffing contributes to burnout, which decreases patient safety and outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Stone, Du, & Gershon, 2007). Ineffective communication and coordination of care amongst nurses and physicians significantly decreases the quality of patient’s outcomes and causes increase in medication errors and inappropriate diagnosis and treatment of patients. Therefore, effective communication training programs should be implemented in the hospital’s educational program to improve effective communication and collaboration between nurses and physicians (Rosenstein & O’Daniel, 2008; Smith, 2004). The process of improving communication between nurses and physicians includes physician and nurse collaboration in projects, interdisciplinary rounds, and continuing education lectures (Puntillo & McAdam, 2006; Smith, 2004).
CHAPTER II
LITERATURE REVIEW

The purpose of the literature review was to scrutinize the current body of information relating to stress, coping, and burnout undergone by mental health nurses. The literature review delivered a superior insight of the ideas and profession as well as direction and arrangement for the concepts and philosophies relating to stress, coping, and burnout, especially in psychiatric units.

The researcher conducted a search of several databases including MEDLINE, CINAHL, Google Search Engine, ProQuest, PubMed, PubMed Central, PsycholINFO, and PsycARTICLES. For additional data, the researcher reviewed the following sources: Journal of Advanced Nursing, Journal of Psychological Nursing and Mental Health Services, and Journal of Clinical Nursing and Mental Health Nursing, International Journal of Nursing Studies and Journal of Psychiatric and Mental Health Nursing. The reviewed research studies focused on psychiatric nurses employed in an assortment of sceneries such as public mental health, criminological, and long-term facilities and acute hospitals. Two of the studies were conducted in the United States, and Australia, fifteen of the studies were conducted in the United Kingdom, one in the Netherlands and Sweden.

Psychiatric-Mental Health Nurses and Burnout

Three of the studies examined for the purposes of this project examined work-related stress relating precisely to nurses employed in acute psychological health units. Thus, Jenkins and Elliott (2004) established to observe the association amongst anxiety and exhaustion amongst competent and incompetent nursing staff ($N = 93$) employed in
acute adult mental hospital in the United Kingdom. Dual groups of participants varied in their discernments of stress. The primary stressor aimed at competent employees was an absence of sufficient employees. The chief stressor for untrained staff was caring for physically intimidating, problematic, or difficult patients. Fifty percent of both assemblies revealed excessive concentrations of burnout. Additional stressors conveyed via both cohorts involved workload, patient-related complications, administrative conflicts, conflicts with other professionals, lack of resources, professional self-doubt. These results were congruent with the conviction that occupational stressors lead to employee exhaustion and burnout.

Sullivan (1993) explored stressors detected by nursing staff (N = 61) employed in the acute mental health in-patient units of two healthcare establishments in the United Kingdom. The biographer also wanted to evaluate the outcomes of stress and detect the kinds of managing tactics applied by the nursing staff employed in this environment. The outcomes showed that nurses most frequently quoted the following stressors: aggressive occurrences, possible attempts of suicide, and surveillance of clients. Other anxieties conveyed involved staffing levels, managerial responsibilities, and experiencing feelings of overextension. The most often used coping approaches were community provision, problem solving, and evasion methods. Coherent with the conclusions of earlier analysis, an elevated amount of burnout was revealed in a preponderance of the mental health nurses. Consistency and strength were not stated in the analysis, which is significant.

Further, a study conducted by Muscroft and Hicks (1998) in Birmingham, England, involved 50 mental health registered nurses and 50 general registered nurses in order to explore work-related stress and coping of the binary varied cohorts of nurses.
This study used questionnaire surveys as a means of information gathering. The outcomes proposed that 50 general registered nurses conveyed more additional work-related stress than mental health registered nurses did. It is significant to communicate that the test size of for each cohort was relatively little.

Trygstad (1986) piloted a US-based study that involved semi-structured discussions with a group of 22 competent nurses employed in critical in-patient settings. The investigator was to detect occupational stressors and reasons that aided the nurses in coping. The results of this study indicated that the greatest significant factors of occupational stress presented were complications in nurses’ dialogue with other RNs or the charge nurse and the skill to collaborate together. Staff employees relations accounted for one third of all anxieties recognized; this comprised inappropriate therapeutic communication and hostile behavior amongst persons and cohorts in the unit. The experiment volume was tremendously small (N = 22). Moreover, the study analysis failed to stipulate whether the cohort involved of RNs, licensed vocational nurses, or general staff.

Managing Stress and Burnout of Psychiatric Nurses Employed in a Diversity of Environments

Kilfedder et al. (2001) piloted an analysis of exhaustion between mental health registered nurses (RNs) employed in the United Kingdom. Members were mental health RNs (N = 510) working in a Scottish Health Service Trust, which incorporated a variety of critical care infirmaries and public settings. Numerous tools were used to calculate stress, coping, burnout, and job approval. The mental health RNs in this analysis had decreased degrees of exhaustion compared to the normative data.
Next, Jeanneau and Armelius (2000) conducted a Sweden-based study about self-perception and burnout amongst psychiatric nursing staff. The sample comprised of psychological psychiatric nurses ($N = 754$) working in a diversity of psychological health care environments including mental health units, small mental health management institutions, criminal wards, and public maintenance centers. The investigators uncovered that extremely exhausted persons had a considerably additional undesirable self-perception than staff who had rated themselves as experiencing low levels of burnout.

Finally, Melchior, Philipsen, Abu-Saad, Halfens, van de Berg, and Gassman (1996) conducted a study that inspected the efficiency of primary nursing interventions in lessening exhaustion levels amongst mental health registered nurses in long-standing locations. A longitudinal study was conducted randomly on 161 mental health registered nurses from five psychiatric hospitals in the Netherlands. The outcomes showed neither reduction nor growth in burnout levels afterwards the main nursing interventions had been presented to the participants.

*Coping with Stress and Burnout in Psychiatric Nursing Students*

A study (Tully, 2004) reviewed for the purposes of studying stress and burnout in psychiatric student’s ($N=35$) in their 74th week of psychiatric training. The survey confirmed that the students preparing to become nurses in the psychiatric setting were greatly stressed. The writer of the study learned that pupils preparing to become nurses in a psychiatric setting were significantly stressed psychologically and that most of the stressors were precise to their education—the quantity of material they were obligatory to acquire, examinations, and panic of failure were greatest stress. The pupils reported that they used coping methods such as consumption of food, liquor, taking prescriptions,
projecting their feelings onto others, and wishing things were different. The pupils report inferior anxiety levels used additional effective management of coping and approaches such as speaking to others, pursuing advice, receiving assistance, altering events so that the condition may become better, and taking problems one day at a time.

Further, Kipping (2000) surveyed the experiences of stress amongst 440 psychiatric nursing students in their interval as pupils and soon after they became employed as nurses in the United Kingdom. Significant anxiety and stressors for pupils were examinations, evaluations, and written work, and assignment and pupil concerns. When the pupils initiated their occupations as mental health nurses, open-ended inquiries were used in order to deliver superior detail about the kind of stressors. The nurses described numerous features of their occupations as stressful as well as patient concerns, colleague relations, functioning of other staff, alterations, and organizational problems. The outcomes of this analysis afforded valued material for nursing instruction and can be implemented broadly to psychiatric nursing.

Community Health Nurses Coping with Stress and Burnout

Public mental health nurses labor in the public instead of infirmaries or long-term care facilities. A study performed by Pinikahana and Happell (2004) calculated stressors and burnout stages and occupation fulfillment in public health nurses \((N = 136)\) working in rural psychiatric mental health facilities in Victoria, Australia. The outcomes of this analysis specified that assignment and inadequate preparation were conveyed very often as the greatest demanding circumstances. The mainstream of public health nurses was discovered to be content with their occupation, and a few of the nurses was feeling extraordinary heights of exhaustion. The exact kind of employment location was not
characterized in detail, and it is merely identified that the psychiatric mental health nurses in this analysis functioned in county and isolated locales through Australia.

Stress, burnout, and managing exhaustion among community health nurses were also the focus of the four separate studies conducted by Burnard, Edwards, Fothergill, Hannigan, & Coyle (2000); Edwards, Burnard, Coyle, Fothergill, & Hannigan (2000, 2001); and Hannigan, Edwards, Coyle, Fothergill, & Burnard (2000). The researchers used questionnaire surveys to analysis stress, burnout and coping amid public health nurses (N = 301). The results specified that public health nurses were suffering great altitudes of anxiety and exhaustion. Half of the cohort was discovered to be psychologically strained and tired thus consequently incapable to deliver excellent nursing provisions to their patients. The intensity of fatigue was superior in public health nurses employed in urban regions than in public health mental nurses employed in county areas. The most stressful characteristics observed by psychiatric public health nurses in these four studies were workload assignments, inadequate resources, extreme documentation, and administration conflicts as well as an extensive range of patient-related topics. Management plans used most frequently by the public health nurses involved colleague support, observation, excellent communication skills, and a wide-range of individual methods, such as recreation and confidence in one’s individual abilities.

Further, Snelgrove (1998) conducted a study on stress and occupation approval in three varied cohorts of nurses employed in the United Kingdom. The sample groups involved health visitors (N = 68), district nurses (N = 56), and CPNs (N = 19). Health visitors are nursing assistants who are employed in hospitals. Region nurses are
extremely experienced nurses who have experienced undergone additional preparation to allow them provide excellent care to residents in the public. CPNs are employed to specifically work with psychiatric clients residing either in their residence or in community-based management residence. Organizational issues, lack of resources, and administrative issues were reported by all three groups of nurses as stressors. The results of the study indicated variances in the stress stages on behalf of each job-related group. Thus, health companions described the utmost stress results and lowest occupation satisfaction scores. District nurses had average stress scores and low occupation approval scores. CPNs also had medium stress results and low job satisfaction scores. This analysis emphasized the significance of placing nurses corresponding to their specialties rather than as a standardized occupation.

Fagin, Brown, Bartlett, Leary, and Carson (1995) conducted a comparison analysis to examine the anxiety levels of 250 CPNs and 323 in-patient psychiatric registered nurses in the United Kingdom. The analysis publicized evaluations amongst infirmary mental health nurses and their public-based psychiatric nurses. A great amount of both cohorts of psychiatric nurses suffered extraordinary quantities of stress and psychological exhaustion owed to the strains of their employment. The nurses who suffered extraordinary levels of stress used additional vacation and sick time, experienced inferior self-confidence, and felt unsatisfied in their occupation. Furthermore, unit-based psychiatric nurses experienced larger moods of depersonalization, or disinterest from their clients, and a diminished intellect of subjective achievement in their occupation as associated to their coworkers employed in the public (Fagin et al., 1995).
Research in Usefulness of Mindfulness-Based Stress Reduction Program by Health Professionals

Implementing programs to decrease job burnout and stress is much needed aimed at the nursing occupation for the overall wellness and long tenure of nurses. Learning about self-care is a powerful health promotion for RNs who care for dementia-type patients in psychiatric units. Thus, Baker (2003) stated that increasing consciousness and endorsing a well-adjusted existence would improve the enduring survival of the health care expert. The mindfulness-based stress reduction (MBSR) program demonstrates mindfulness and kindness regarding individuals’ identity and others. Kabat-Zinn, Lipworth, and Burney (1985) designed a two-week MBSR program. Members attend a group for 3 hours per week and learn introspection of thoughts, Hatha Yoga, and other official and unofficial techniques to increase mindfulness. Endorsing oneself through loving-kindness is the fundamental of the curriculum and the first phase to the mindfulness events in this program. The MBSR curriculum involves of developing mindfulness calisthenics to generate consciousness and frankness in the person. MBSR could be explained as realistic and non-deliberate (Grossman, Niemann, Schmidt, & Walach, 2004).

Although several MBSR studies focusing on health professions have been conducted, neither study has focused on RNs alone. The next section of this chapter discusses the investigation outcomes proceeding of the use of MBSR by healthcare specialists.
Cohen-Katz et al. (2005) implemented a randomized control design study using the MBSR curriculum as an intervention. The rationale of this study was to observe whether the MBSR curriculum could reduce exhaustion and emotional anguish and improve mindfulness in infirmary employees. In this study, the Maslach Burnout Inventory (MBI), Brief Symptom Inventory (BSI), and the Mindfulness Attention Awareness Scale (MAAS) were used as measurement tools. The addition of benchmarks for this study was consistent communication with patients, employment at the infirmary, being English dialogue, and being above 18 years of age. Staff participants with drug addiction problems or active inclinations of suicide were omitted from this study.

Approval was acquired from 27 employees; 14 were placed in randomized control intervention cohort, and 13 were placed in the waiting cohort. Ninety in each hundreds of the staff participants were nurses and the rest were in supportive roles such as clergy, respiratory therapist, and social workers. Occasions to be present at the MBSR program and its expenses were funded by the organization and the wellness course.

Measurement tools were implemented before intervention, directly afterwards, and ninety days post-intervention. In this study, the intervention cohort had a 7% attrition rate. The mean age of the nursing staff was 46; 100% of the members were women.

No significant variances were found amongst the intervention cohort and the waiting cohort before the intervention intended to increasing mindfulness and decreasing burnout and emotional distress. However, statistically momentous affirmative variances transpired amongst the intervention cohort and the waiting cohort on the average totals post-intervention aimed at mindfulness. Post-intervention scores on the MBI scale
showed a significant variance. A substantial contrast was also found for individual achievement among the intervention cohort, directly post-intervention but then no different individual achievement was found at the three-month point.

A within-group analysis of the intervention group confirmed momentous reduction in psychological burnout on the MBI scale directly post-intervention and ninety days post intervention. The amount of registered nurses with emotional stress recorded preceding the intervention declined equally in the intervention cohort and also in the waiting group but not considerably.

A randomized control design and acquiring the understanding of the use of MBSR by health care givers in acute care settings were the strengths of this analysis. The boundaries of the analysis involved the small trial size, similarity of the trial, and prejudice presented by paying the MBSR program course fees for the hospital staff.

Further, in their analysis, Galantino, Baime, Maguire, Szapary, and Farrar (2005) appraised the connection amongst somatic and emotional stress procedures before and post-intervention of the MBSR. Eighty-four health care workers participated in a quantitative nonrandomized research study on using the MBSR program. The health care employees participated in the study included directors and direct bedside care givers from a university infirmary setting. Ninety-six percent of the members were female with an average age of 43. Anxiety and stress were measured by salivary cortisol levels accumulated between 5 p.m. and 7 p.m. The Profile of Mood States-Short Form (POMS-SF) was used to study levels of anxiety and stress and mood disorders; MBI was used to analyze burnout; and the Interpersonal Reactivity Index (IRI) was used to analyze empathy.
Eighty-two percent of the participants completed the surveys, and 61% finished the pre- and post-cortisol test. There were no important conclusions conveyed for the cortisol levels from reference point. However, the Emotional Exhaustion subscale of MBI and the subscales showed a significantly difference of the POMS-SF scale. The analysis did not exhibit any deviations in salivary cortisol levels over time; the analysis did not validate a correlation amongst the cortisol level and the numerous emotional procedures.

The strong points of this research study encompassed acceptable trial size and attainment of additional data of the conclusions of using the MBSR program. Patient gratification improved a quarter following MBSR was implemented, which could imply long-lasting outcomes. The restrictions of this analysis were absence of a control cohort, nonrandomized design, and the significant attrition. It was also uncertain from the explanation of the trial whether the administrators were clinically equipped and in what clinical area the nurses specialized.

Next, Mackenzie et al. (2006) led an analysis using a test sample of 30 nurses and nursing assistants. A randomized control pilot analysis of the effectiveness of a reduced style of MBSR employing the dual studies and experience of Kabat-Zinn (1990) and Segal, Williams, and Teasdale (2002) to compare a waiting cohort and a control, or intervention, cohort. The intervention cohort comprised of four 30-minute group meetings. Participants were taught to exercise 10 minutes per day, five days per week contrasted to 45 minutes per day, six days per week in the customary MBSR program established by Kabat-Zinn (1990).

Psychosomatic methods were concluded at starting point and after training. MBI, the Smith Relaxation Dispositions Inventory (SRDI), Intrinsic Job Satisfaction subscale
of the Job Satisfaction Scale (JSS), Satisfaction with Life Scale (SWLS), and Antonovsky’s Orientation to Life Questionnaire were used to compute overall well-being. Frequent methods of assessment of variance (ANOVA) were employed on the outcomes of cohort participation over time on the subscales of burnout, happiness of consistency, life contentment, recreation, and employment satisfaction.

Important statistical results were found in psychological fatigue, detachment from work environment, and employee-related individualized accomplishments among the intervention cohort and the wait-list cohort. Members who had finished the mindfulness program verbalized momentous contentment with life, comfort, and decrease stress ratings. No momentous outcomes were acquired for employment fulfillment or feelings of soundness.

The strong point of this research analysis were the randomized control design and increased data of the outcome of MBSR in nurses and nursing assistants. The methodological segment was organized and clearly outlined the psychometric measurement tools and their reliability. The restrictions of this research analysis included a small sample size that consisted of only two types of health care specialist. It was not clear if the researchers managed the extracurricular components that could have determinant the emotional constants. This research analysis was the only one found during the literature review that altered the MBSR program and studied effectiveness in a medical locale.

Schenström, Rönnberg, and Bodlund (2006) executed a potential pilot study concentration on 52 health care specialists in a primary care location in Sweden. The goal of this research analysis was to assess the practicability and effectiveness of mindfulness
and thinking approach preparation for health care specialist as well as to analyze emotional issues connected to health. The sample consisted generally of doctors ($N = 29$); other health care specialists ($N = 23$) included nurses, physical therapists, occupational therapists, and social workers. Two doctors taught 50 hours of informative and thinking assertiveness calisthenics and mindfulness based on the MBSR program over a progression of numerous weeks. MASS, the WHO-5 Well-Being Index, and dual graphic analog scales to measure stress were used pre-intervention, instantly post-intervention, and ninety days post-intervention. A survey was implemented to evaluate the strength of mindfulness exercise at home.

There was a statistically significant increase in mindfulness that occurred after the implementation of mindfulness based stress reduction program. Decreases in strain were conveyed on both graphic analog scales. Persons who applied mindfulness more frequently conveyed a statistically important gain in mindfulness instantly post-intervention and at the ninety days follow-up.

The potencies of this research analysis encompassed a low dropout rate and longitudinal emphasis achieved via methods at ninety day post-intervention. The restrictions of this examination included deficiency of a control cohort, no randomization, and the use of the untested MAAS tool on Swedish population. In addition, due to the mixture of MBSR with reasoning attitude training, it is uncertain which program generated the important improvement in happiness.

Finally, Shapiro et al. (2005) executed a potential, randomized, organized pilot analyze focusing on 38 members working in a health care field. The sample included doctors, health care provider, social workers, physical therapists, and psychologists were
randomly placed in the MBSR intervention or a wait list. The role of the analysis was to analyze the outcomes of MBSR on health care specialists presently employed in medical institution settings. Tools included BSI, the Perceived Stress Scale (PSS), SWLS, MBI, and the Self-Compassion Scale (SCS). Forty-four percent of the 18 members in the intervention cohort and 10% of the 20 members in the control cohort stopped participating in the research analysis. There were important statistical advances shown in the intervention group of self-compassion and stress. Statistically no important change of state in diminishing burnout rates was ascertained.

The potency of this research analysis involved using the randomized control design and contributing to promote knowledge of using MBSR by health professionals. High attrition rate and small sample size were limitations of the research it is implied that the intervention cohort may have had an improvement in stress due to stress being recorded higher at the baseline. It is probable that higher quantities of stress may have occurred or those who MBSR was not effective or satisfactory left the study. This may have caused a selection bias to occur.

*Qualitative Studies Used by Health Professionals*

Cohen-Katz et al. (2005) conducted a qualitative design study arranged in the same group they used for the quantitative branch of their analysis. Ninety percent of the 27 members were nurses employed in a diversity of impatient care setting in the infirmary. Explanations designed for joining in the analysis were domestic stress—becoming older, sickness, or current loss of a relative. Three percent of the participants reported the strain of being employed part-time and performance apprehension while working. Twenty-seven percent recounted challenging occupations, and 21% conveyed
obtaining a new occupation as the chief purpose for job-related anxiety.

Qualitative data evaluation included assessment of 46 unrestricted questions provided in the course of the MBSR program, two consultations with the vice-president for patient care, and a sixty minute focus cohort with seven of the 27 members. Each of the researchers independently transcribed and reviewed the interviews recorded during the focus group. Subject matter and topics were acquired from the records, using a 6-item codebook created by the research committee. Agreement was acquired via two of the three researchers’ approving on the coding for five exam records. The remaining manuscripts were labeled by the primary researcher and evaluated via the investigation panel. The NVIVO software was used following the consensus labeling. Topics that appeared from the focus-cohort consultations were “increase in empathy and appreciation of others,” “increased relaxation,” and “learning how to be in the present moment.” Other themes were “patience,” “calmness,” “letting go of worry,” and “being fully present in relationships.”

The vigor of this analysis incorporated implementing the grounded theory method to analyzing topics, the explanation of the interpretative descriptions, and authentication of the information through several coders and agreement, which increased reliability (Sandelowski & Barroso, 2003). The report is structured via section headings and contains linguistic of the participants. The singular focus group was a limitation of this study. It was uncertain from the analysis narrative if continuing outcomes followed. Finally, the research team should have mentioned if the participants validated the transcripts for accuracy.
Numerous infirmaries are implementing procedures to enhance the labor atmosphere and circumstances, using quality-improvement and competence procedures to help eradicate obstacles on behalf of the distribution of extraordinary quality of care. Individual charge over problematic circumstances initiates with recognition of stressors and taking the liability to deal with stress (Miller & Smith, 1993). Reorganizing procedures for dealing with stress and burnout and observing situations as a unit to help caregivers cope with the situation will improve working conditions and decrease burnout and stress in psychiatric units. Self-care courses are necessary in locked Alzheimer’s type dementia units to assist nursing care givers in their managing of anxiety and promotion of internal self-awareness. Through teaching nurses to stabilize and maintain inner balance and prevent stress and burnout, these courses could lead to advancement in nursing practice, individual well-being of nurses, and general retention of the nursing professionals.

The results of the quantitative and qualitative studies discussed above are valuable in directing the growth of stress reducing programs for psychiatric nurses to support in enhancing nurses’ job happiness, lessening stress and burnout, enhancing affirmative coping mechanisms, and enhancing the general well-being of nurses. Mindfulness practices are rooted in the theoretical Buddhist teaching and methods in Tibetan culture (Kabat-Zinn, 1990). The MBSR intervention program implements emotional and physical outcomes that support the members’ general state of health. The MBSR program will be useful in everyday practice for psychiatric nurses working in locked units, for orientation programs for psychiatric RNs working in locked units, and for continuing education programs. This program aims to expand knowledge of mindfulness as it
communicates to possible gains to nurses and their employment functioning and efficacy, which will improve quality of care.

In summary, several reviewed studies have shown encouraging outcomes in nursing staff presently employed in the health care field. The analyses that concentrated on nurses and nursing assistants employed in infirmary locations confirmed a statically substantial growth in mindfulness and important reduction in psychological exertion (Cohen-Katz et al., 2005; Mackenzie et al., 2006).
CHAPTER III
METHODOLOGY

Conceptual Framework

The conceptual framework of this project consists of numerous theoretic works led by three firm theoreticians. A conceptual structure is a collection of comprehensible thoughts or perceptions systematized in a method that creates them to be simple in order to convey to others. The purpose of this project is to decrease the perception of tension, burnout and stress in psychiatric-mental health nurses who provide direct care in psychiatric units to Alzheimer’s type dementia patients. In the process of the project, the burnout and occupational stressors perceived by psychiatric nurses will be measured. The implementation of an MBSR intervention should reduce the perception of stress and will be measured by giving pre- and post-tests of the previous MBI-HSS scale in a post two week period after MBSR has been implemented. In order to approach this assignment in a systematized and methodical way, three theoretic models will be utilized as a guide: Selye’s (1974) stress health promotion theory, Lazarus and Folkman’s (1984) coping theory, and Dorothea Orem’s self-care theory (Taylor, 2006).

Theoretical Framework

Nursing Theories

The following main hypotheses of Dorothea Orem’s self-care theory are the basis of this MBSR program: (1) individuals should be self-sufficient and accountable for their individual care and for family that may also need care, (2) the nursing profession is a method of engagement among two or more individuals, and (3) an individual’s understanding of impending health complications is essential for promoting self-care
activities (Tomey & Alligood, 2002). According to Orem’s theory, the aim of nursing is to provide the client or family member’s needs in being proficient of meeting the client’s self-care goals. However, nurses must continue a normal condition of health and be balanced in order to care for others (Taylor, 2006). Dorothea Orem’s general theory of nursing consists of three parts: theory of self-care, theory of self-care deficit, and theory of nursing systems (Taylor, 2006).

Dorothea Orem’s collective self-care requisites include lifecycle practices and the conservation of the veracity of the individual’s structure and performance; equilibrium among recreation and relaxation and among privacy and social contact; and deterrence of dangers to human lifecycle, health, and encouragement of human functioning (McEwen & Wills, 2002). This theory directs clinical practice for a supportive, educative system to enhance nurses’ health and the excellence of care for this population.

Dorothea Orem’s theory delivers a complete foundation for the practice of professional nursing. It has usefulness for the practice of nursing in the topics of nursing practice, nursing education administration, and nursing research. Dorothea Orem’s theory is a contemporary approach—specific to nursing—with the ideas of health advancement and health preservation.

**Stress**

Hans Selye, a Canadian endocrinologist and renowned stress theorist, described stress as “the nonspecific responses of the body to any demand made upon it” (Selye, 1974, p. 27). Selye named it the general adaptation syndrome (GAS). GAS has three distinguishable phases: alarm, resistance, and exhaustion. These three phases happen consecutively. When stress raises the anxiety, this instructs GAS, and is not eliminated or
managed with; the body develops into conflict and eventual fatigue. Recovery is an outcome substitute to fatigue when the basis of stress is either eliminated or managed with successfully (Selye, 1956). Selye thought that the outcomes of the resistance phase of GAS result in the steady tiring down of what he characterized as “weak link”—body parts or structures. This causes the body to be overcome with stress and overtiredness.

Coping

Richard Lazarus is an additional well-accepted stress theorist. Lazarus developed exclusive model amplification in what way our psyches work when identifying possible stressors. Lazarus’ theory of emotional stress interprets the belief that individuals or stuffs develop stress as soon as they feel threatened of their well-being. The danger can be either psychological or biological in description, and the observation of the incentives decides whether they develop into stressors (Lazarus, 1966). Lazarus named the observation of possible stressors “threat” and the definite assessment of incentives hazard, which is stress, “the appraisal process.” Primary assessment controls whether the stressor is a hazard; the secondary assessment regulates whether the person is skillful of managing with the hazard; and the third assessment—the intellectual reassessment—pulls on the material from the original two assessments (Lazarus & Lazarus, 1996).

According to Lazarus and Folkman (1984), stress is factual or observed unevenness amongst the atmosphere and a person’s capacity to manage with or regulate to the disproportion. People tolerate stress by constantly managing or adjusting to the anxieties of continually altering surroundings.
Conceptual Links of Theory

Dorothea Orem (Taylor, 2006) believed nurses must maintain a normal state of health and be balanced in order to care for others. As Selye (1974) also noted, the usefulness of transcendental meditation technique prepares the nervous system to relax so that it can live with stress better. In addition, Lazarus and Folkman (1984) posited that human beings endure by continuously managing with or adjusting to the anxieties of a continually altering milieu. Thus, these three theorists believed in a stress response and that the body must find a positive way to cope in order to be balanced and healthy in everyday life processes. These theorists’ beliefs support the concept of implementing a mindfulness-based stress-reduction intervention program to reduce the perception of stress and burnout in psychiatric professional nurses who work in locked units.

Aims of the Program

The aim of this program is to determine whether an MBSR intervention will decrease the perception of stress and burnout in nurses who work in Alzheimer’s type dementia psychiatric units. The objective for implementing the program began with the researcher’s aspiration to advance the psychological well-being of registered nurses (RNs) employed as professional unit nurses as well as the nursing care provided by these nurses to patients with Alzheimer’s type dementia.

Program Design and Setting

The quantitative program design targets RNs working in an Alzheimer’s type dementia locked unit in a rural hospital locale. The primary goal of implementing this program is to test the effectiveness of an MBSR intervention and to analyze whether the perception of stress and burnout will decrease post-intervention in RNs who care for
patients with Alzheimer’s type dementia. Standardized measures of the Maslach Burnout Inventory–Human Services Survey (MBI-HSS) will be given pre- and post-MBSR intervention (Maslach et al., 1996).

Program Members

The main population aimed at this program is psychiatric RNs working in a locked psychiatric unit within a small rural hospital. Collectively, each member has to be (a) male or female, (b) 18 years of age or older, (c) working either part- or full-time, (d) presently employed in a secured psychiatric unit, (e) currently licensed as an RN. Prohibiting conditions required that members cannot be below the age 18 years, licensed vocational nurses, nursing assistants, and nurse directors.

Methods of Measurement

The Maslach Burnout Inventory–Human Services Survey (MBI-HSS)

The Maslach Burnout Inventory–Human Services Survey (MBI-HSS) is a 22-item self-report gauge of burnout (Maslach et al., 1996). MBI-HSS is utilized for employees that devote time with other individuals. The elements are assembled into three subscales: Emotional Exhaustion, Depersonalization, and Personal Accomplishment. Emotional Exhaustion subscale is categorized by elements such as “I am emotionally drained from my work.” Depersonalization captures negative attitudes towards patients with items such as “I feel I treat some recipients as if they were impersonal objects.” Finally, Personal Accomplishment subscale measure in what way the person evaluates himself or herself, predominantly in relation to working with patients. This subscale includes such items as “I have accomplished many worthwhile things in this job.” Items are rated on Likert-type scales from 0 = never to 6 = every day. Upper scores on Emotional Exhaustion and
Depersonalization subscales reflect advanced levels of burnout, whereas low scores on Personal Accomplishment subscale indicate high concentrations of burnout.

In Maslach et al.’s (1996) sample, internal consistency reliability coefficients (Cronbach’s alpha) for the subscales were .922 for Emotional Exhaustion, .616 for Depersonalization, and .742 for Personal Accomplishment, with Depersonalization decreasing beneath the conventional .70 adequacy range. Test-retest reliability measured by other investigators has ranged from low to moderately high, and all reliability testing for this scale’s coefficients was substantial beyond the .001 level. The MBI-HSS has also remained to be found to have moderate convergent and discriminant validity. The tool was originally designed to be used in human services including nursing services.

Assumptions

1. Perception of burnout can be measured.

2. MBSR programmatic interventions can decrease the perception of stress and burnout in nurses and improve patient outcomes.

PICOT Question

The following PICOT question will guide this project:

1. Will implementing a mindfulness-based stress reduction (MBSR) program decrease the perception of stress and burnout and improve coping mechanisms in psychiatric nurses who care for patients with Alzheimer’s type dementia?

The PICOT question in this program indicates the (population) as the nurses; the (intervention) will be the implementation of a mindfulness program, (compared) to not implementing the mindfulness program; a decrease in the perception of stress and burnout will be the (outcome) over a four-week period (time frame).
Program and the DNP Essentials

This program will implement an MBSR intervention to decrease the perception of stress and burnout and improve coping mechanisms. The American Association of the Colleges of Nursing (AACN) (2006) describes the eight Doctorate of Nursing Practice (DNP) essentials for evidence-based practice. Implementation of this project will meet seven of the eight DNP essentials as presented in Table 5.

Table 5

*DNP Essentials and the Project’s Compliance*

<table>
<thead>
<tr>
<th>DNP Essentials</th>
<th>Project’s Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Organizational and systems leadership for quality improvement and systems thinking</td>
<td>Implementing this program will decrease burnout in RNs and will improve staff morale as well as organizational systems while decreasing staff turnover and sick days.</td>
</tr>
<tr>
<td>II. Clinical scholarship and analytical methods for evidence-based practice</td>
<td>This program has opportunities to disseminate evidence-based practices based on best-practice findings. Leadership and advocacy will be implemented with the program.</td>
</tr>
<tr>
<td>III. Information system/technology and patient care technology for the improvement and transformation of health care</td>
<td>Information systems and technology will be used to evaluate and look up evidence-based practice regarding burnout. The program will be placed in organizational technology systems for educational purposes.</td>
</tr>
<tr>
<td>IV. Health care policy for advocacy in health care</td>
<td>The program can be implemented into policy of organization for new hires and used in ongoing training for burnout annually through staff development.</td>
</tr>
<tr>
<td>V. Interprofessional collaboration for improving patient and population health outcomes</td>
<td>This program can be presented to other facilities as a consultation program for RNs to decrease stress in locked psychiatric units.</td>
</tr>
<tr>
<td>DNP Essentials</td>
<td>Project’s Compliance</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>VI. Clinical prevention and population health for improving the nation’s health</td>
<td>This program will involve risk reduction and will prevent or decrease burnout thus improving health care outcomes.</td>
</tr>
<tr>
<td>VII. Advanced nursing practice</td>
<td>This program can be utilized in advanced nursing practice to implement education and prevent burnout in nurses. It can be used as scientific underpinnings for practice by improving quality of care in this population.</td>
</tr>
</tbody>
</table>

Note. See AACN (2006).

The DNP’s role is being patients’ advocate and leader while addressing health care disparities in the community. The goal of the intervention is to decrease the perception of stress and burnout in RNs who care for Alzheimer’s type dementia patients in locked psychiatric units and thus to improve nurse-patient interactions and patient outcomes.

Sources of data. The data analysis will include descriptive analysis of the demographic tool.

Data analysis. The data analysis will include examination of the results of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS).

Ethics and human subject issues. After obtaining the University of Southern Mississippi’s Institutional Review Board’s (IRB) approval, the researcher will implement the project focusing on RNs working in a locked psychiatric unit in a rural area of southern Mississippi and caring for patients with Alzheimer’s type dementia.
Program Implementation

MBI-HSS will be administered to the participants before implementing the MBSR program. The measurement scales will be re-administered one week later to reassess the participants’ perception of stress and burnout coping behavior after the implementation of the program. The program will include two two-hour group sessions of mindfulness-based stress reduction. This program will be implemented two Saturdays at 45 minutes per session. Further, the participants will be asked to practice 5-15 minutes per day of casual preparation, five days per week for two weeks. During program implementation, periodic breaks will be allowed so the participants can relax and informally discuss the ideas that have been presented. Visual aids will be used to allow the participants to see what they are hearing. The setting will be arranged in a less formal way for the participants to see each other and the presenter. This will allow for interaction between the study participants.

Upon the implementation of this program, the researcher will stay on schedule, call the participants by name, provide appropriated handouts, summarize ideas in periodic intervals, schedule breaks for the participants, ask open-ended questions, and start and finish on time. After the implementation of the program, the researcher will follow up with a question-and-answer session to assess if the participants are applying ideas learned during the MBSR program implementation.
Mindfulness-Based Stress Reduction Key Concepts:

Structure, Methods, and Program Objectives

Structure and Methods

A. Cohort Pre-Program Orientation (2.5 Hours) explaining program administering The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) to access level of burnout before implementation of program. Informed consents will be signed for participation if needed. Objectives will be covered and a verbal presentation will be given on how mindfulness stress reduction can decrease stress and improve coping in their professional life and everyday life of nurses. Explain the profound impact of burnout syndrome on nursing.

B. Two-weekly classes for two Saturday for (2 hours) in duration.

C. “Formal” Mindfulness Mediation Methods will be presented with group participation.

a. Body scans Medication-sitting and supine in a chair medication focusing on concentrating on tight parts of your body, internally at that time without distractions. (15 minutes approximated time each session).

b. Calm Hatha Yoga-Practiced with mindfulness consciousness of the body in calm quite environment. This contains light stretching exercises. For example shoulder rolling, neck rolls, sitting in a chair and bending forward to touch toes and holding for 5 to 10 seconds and returning to sitting position. (At no time will I touch the participants). Fifteen minutes approximated time each session.
c. Sitting Mediation-Mindfulness of breathing, body, emotional state, thoughts, feelings and selection fewer awareness. Breathing exercises will be implemented with cleansing breaths inhaling through nose and exhaling out through nose and exhaling out through the mouth. (15 minutes approximated time).

D. “Informal “Mindfulness Medication Practices (mindfulness in everyday life) will be taught. (Lecture 30 to 45 minutes with questions and answer sessions.
   a. Mindfulness of enjoyable and unpleasant happenings and your surroundings.
   b. Mindfulness of breathing. Will illustrate cleansing breaths and how to refocus on task to decrease stress.
   c. Purposeful consciousness of regular activities and proceedings such as consumption food, climate, driving, ambulating, and consciousness of personal communication with oneself.

E. Daily homework assignments will be given which consist of a minimum of 45 minutes per day of formal mindfulness practice and 5-15 minutes of casual practice, 6 days per week for the complete length of the program.
   a. It is expected for the participants to write down in booklets any examination of interferences of mindfulness and growth and incorporation of mindfulness in daily task and at work. It is expected for the participants to communicate individually and participate in group dialogue about their experiences. (Group participation deepens the experience and gives a therapeutic dialogue on an individual bases). Case studies will be presented to the group to explore different situations to use mindfulness in personal life and professional life. Each class session for two Saturdays in two weeks will practice formal and
b. Informal mindfulness and discuss homework in a group setting...

F. Incorporation of the post assessment instrument, the MBI-HSS, to access level of burnout after program implementation.
   a. Total in-class hours: 4 hours
   b. Total homework assignments hours: 23 hours
   c. Complete cohort Orientation Gathering time: 3 hours

**Important Features of Mindfulness Program**

1. A fundamental component to improve self-care
2. Preparation in conscious thought
3. Scholastic orientation
4. Cohort arrangement 7-10 members
5. Personally customized guidelines when required
6. Highly participatory format with group
7. Strong support system
8. Self-actualization within the framework of a collective correlation among members, and MBSR instructor
9. Interactive dialogue between instructor and participate dialogue to discover perception, psychological and behavioral habits and patterns that may impede acquiring information, growth, healing plus stress reduction.
10. Temporary intervention: This MBSR is a short-term period 2-week. The arrangement is projected to promote member self-regulation and maintenance.
Objectives

1. Participants should be able to apply MBSR in their personal life and professional practice.
2. Participants should be able to practice three mindfulness meditation techniques.
3. Participants should recognize how stress is expressed in the body and mind (Body scan techniques).
4. Participants will use techniques to maintain and regain composure during a busy work day.
5. Understand the profound impact of burnout syndrome on nursing.

Potential Benefits

Potential benefits from participating in this project include improved coping mechanisms and decreased perception of stress and burnout in nursing staff caring for Alzheimer’s type dementia patients in long-term care settings. This project will help the participants develop positive coping mechanisms and decrease the perception of stress and burnout. This intervention ensures the potential to enhance nurses’ productivity and quality of care. This project may also decrease staff turnover and improve retention.

Risks

Minimum risk is involved in the participation in this project. The researcher will educate the administrators and the director of nursing, who is an RN, on the subject of protecting human research participants. The researcher will make an oral presentation prior to obtaining informed consent for program participation to assure understanding of the program components. Participation is voluntary, and the researcher will obtain informed consent from all subjects before conducting the program to assure voluntary
participation. All registered nurses (RNs) have the right to withdraw informed consent during any part of the program without penalty.

If the participants experience any emotional distress related to coping or burnout, a licensed advanced psychiatric practice nurse will be available. There is always a risk that questions on burnout pre- or post-test will make participants uncomfortable or anxious. Those who participate in this study will be reassured that this program is only intended to improve their level of knowledge and perception of the perception of burnout, stress, and coping.

Program Duration and Location

The proposed project will be presented in a locked psychiatric unit for patients with Alzheimer’s type dementia on a locked unit located in rural hospital. The meeting room is spacious enough to comfortably accommodate the participating nursing staff and to provide sufficient room for privacy when answering questions. Approximately two hours will be allotted for the oral presentation and completion of informed consent forms, the scales, and demographic survey forms. One hour will be allotted for the evaluation of the program.
CHAPTER IV

ANALYSIS OF DATA

Discussion of Results

Intervention

In the process of the project, the perception of burnout and occupational stressors perceived by psychiatric nurses was calculated. The implementation of a mindfulness-based stress reduction program intervention reduced the perception of stress and was measured in a pre-and post-test of the previous MBI-HSS scale in a post two week period after MBSR had been implemented. The participants were given booklets to write down feelings of hindrance and development and integration of mindfulness in daily task at work.

The mindfulness-based stress reduction program (MBSR) was initially adjusted from a five- to eight-week program (Kabat-Zinn et al., 1985) to a two-week program due to time constraints. In the future, when it is applied to practice, it will be an eight-week program. The MBSR program is a group-based, two-week curriculum at two hours per week with preparation meetings throughout the week and homework assignments. This program was implemented among psychiatric registered nurses who are employed in a locked psychiatric unit. The program was used to promote stress reduction and to decrease the perception of burnout. The participants were given booklets to write down feelings before and after MBSR were implemented. This information was part of homework assignments and was discussed during group sessions.
Data Analysis and Findings

Information was analyzed using Social Package Statistical Software (SPSS), version 21 (IBM Corp. Released 2013) and Excel Database. Ten participants (100%) completed the MBSR program. All of the participating registered nurses were female; four were African American, six were Caucasian, none were Asian, Hispanic or American Indian. The average age of the participants was 27. The additional demographic features are shown in Table 6.

Table 6

Demographic Features of Members

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (N=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: (25-30)</td>
<td>Mean=27</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
</tr>
<tr>
<td>Caucasian</td>
<td>6</td>
</tr>
<tr>
<td>Years of nursing experience</td>
<td>9 to 10</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>8</td>
</tr>
<tr>
<td>Single</td>
<td>2</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
</tr>
<tr>
<td>Nursing education/training</td>
<td></td>
</tr>
<tr>
<td>Associate degree</td>
<td>0</td>
</tr>
<tr>
<td>Bachelorette Degree</td>
<td>10</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>0</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>0</td>
</tr>
</tbody>
</table>

The MBI-Human Services Survey (MBI-HSS) was implemented for this mindfulness-based program. Three subscales of this survey were utilized to assess the
perception of burnout: Emotional exhaustion, Depersonalization, and Personal Accomplishments. Leiter and Maslach (2013, p. 3) defined the three subscales and what they measure:

- Emotional Exhaustion measures feelings of being emotionally overextended and exhausted by one’s work. It is a depletion of emotional energy, distinct from physical exhaustion or mental fatigue. Emotional Exhaustion is a clear signal of distress in emotionally demanding work.

- Depersonalization measures an unfeeling and impersonal response toward recipients of one’s service, care, treatment, or instruction. Depersonalization is a problem in careers that value and mandate personal sensitivity to service recipients.

- Personal Accomplishment measures feelings of competence and successful achievement in one’s work. Personal Accomplishment emphasizes effectiveness and success in having a beneficial impact on people.

Table 7

Scores of the Three Subscales of the MBI-HSS

<table>
<thead>
<tr>
<th></th>
<th>Emotional Exhaustion</th>
<th>Depersonalization</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>High:</td>
<td>27 or over</td>
<td>13 or over</td>
<td>39 or over</td>
</tr>
<tr>
<td>Moderate:</td>
<td>17–26</td>
<td>7–12</td>
<td>32–38</td>
</tr>
<tr>
<td>Low:</td>
<td>0–16</td>
<td>0–6</td>
<td>0–31</td>
</tr>
</tbody>
</table>
Before the implementation of the MBSR program, the baseline of the 10 participants was evaluated using the Emotional Exhaustion subscale of the MBI-HSS. The participants scored 31.3 (high). On the Depersonalization subscale of the MBI-HSS they scored 22.2 (extremely high). The participants scored 29 (low) on the Personal Accomplishment subscale before the MBSR program was implemented. This showed the participants’ levels of emotional exhaustion, depersonalization, and personal accomplishment, which is presented in Table 7.

### Table 8

*Members’ Scores on the Emotional Exhaustion, Depersonalization, and Personal Accomplishment Subscales Before Implementation of MBSR*

<table>
<thead>
<tr>
<th>MBI-HSS Subscale</th>
<th>Mean Score</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>31.3 (high)</td>
<td>(N=10)</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>22.2 (extremely high)</td>
<td>(N=10)</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>29 (low)</td>
<td>(N=10)</td>
</tr>
</tbody>
</table>

Note. As Emotional Exhaustion and Depersonalization scores increased, Personal Accomplishment scores decreased.

Further, Table 9 displays the participants’ scores on the three subscales before and following the application of the MBSR program. The average scores are represented as follows: A (Personal Accomplishment pre-intervention); B (Personal Accomplishment post-intervention); C (Emotional Exhaustion pre-intervention); D (Emotional Exhaustion post-intervention); E (Depersonalization pre-intervention); and F (Depersonalization post-intervention).
### Table 9

**Pre- and Post-Intervention Average Scores of the Members on the Personal Accomplishment, Emotional Exhaustion, and Depersonalizations Subscales**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.34</td>
<td>1.40</td>
<td>1.31</td>
<td>1.2</td>
<td>1.11</td>
<td>1.2</td>
</tr>
<tr>
<td>2.32</td>
<td>2.39</td>
<td>2.31</td>
<td>2.10</td>
<td>2.11</td>
<td>2.9</td>
</tr>
<tr>
<td>3.34</td>
<td>3.41</td>
<td>3.34</td>
<td>3.14</td>
<td>3.12</td>
<td>3.1</td>
</tr>
<tr>
<td>4.25</td>
<td>4.36</td>
<td>4.19</td>
<td>4.10</td>
<td>4.10</td>
<td>4.2</td>
</tr>
<tr>
<td>5.22</td>
<td>5.42</td>
<td>5.25</td>
<td>5.4</td>
<td>5.6</td>
<td>5.0</td>
</tr>
<tr>
<td>6.20</td>
<td>6.40</td>
<td>6.24</td>
<td>6.9</td>
<td>6.6</td>
<td>6.1</td>
</tr>
<tr>
<td>7.36</td>
<td>7.42</td>
<td>7.42</td>
<td>7.5</td>
<td>7.3</td>
<td>7.9</td>
</tr>
<tr>
<td>8.35</td>
<td>8.38</td>
<td>8.38</td>
<td>8.7</td>
<td>8.7</td>
<td>8.1</td>
</tr>
<tr>
<td>10.33</td>
<td>10.37</td>
<td>10.29</td>
<td>12.2</td>
<td>10.8</td>
<td>10.1</td>
</tr>
</tbody>
</table>

287/10=29 389/10=39 289/9=31.3 85/10=9 76/10=22.2 31/10=3.1 (F)

Note. N=10 A. (Personal Accomplishment pre-intervention); B (Personal Accomplishment post-intervention); C (Emotional Exhaustion pre-intervention); E (Depersonalization pre-intervention); and F (Depersonalization post-intervention)

### Table 10

**Members’ Scores on the Emotional Exhaustion, Depersonalization, and Personal Accomplishment Subscales After Implementation of MBSR**

<table>
<thead>
<tr>
<th>MBI-HSS Subscale</th>
<th>Mean Score</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>9 (low)</td>
<td>(N=10)</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>3.1 (low)</td>
<td>(N=10)</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>39 (high)</td>
<td>(N=10)</td>
</tr>
</tbody>
</table>

Note. As Emotional Exhaustion and Depersonalization scores decreased, Personal Accomplishment scores increased.
Statistical Analysis: t-test

Depersonalization Subscale $t$–test=1.020(<.05):

Based on this $t$–test there was not a statistical significance in the difference in the pre-intervention scores and the post intervention scores. Therefore, the intervention did not cause the change in scores and there may have been other variables that had an effect on the change in scores, such as group environment and participation.

Emotional Exhaustion Subscale $t$–test=6.208 (<.05):

Based on this $t$–test there was a statistical significance in the difference in the pre-intervention scores and the post-intervention scores. Therefore, the intervention did have an effect on the change in scores.

Personal Accomplishment Subscale $t$–test = 0.838 (<.05):

Based on this $t$–test there was not a statistical significance in the difference in the pre-intervention scores and the post intervention scores. Therefore, the intervention did not cause the change in scores and there may have been other variables that had an effect on the change in scores.

Discussion

Effectiveness of the MBSR Program

Emotional Exhaustion scores after implementation of MBSR:

- Emotional Exhaustion 9 (low)
- Depersonalization 3.1 (low)
- Personal Accomplishment 39 (high)

Findings show that after the MBSR program was implemented, the participants’ emotional exhaustion and depersonalization scores declined, whereas individual
accomplishment improved. These subscales indicated that the MBSR program was effective in reducing the participants’ perception of stress-related outcomes. These findings correlate with the research results obtained from using this program with nurses, conducted by Penque (2009), Cohen-Katz et al. (2005), and Mackenzie et al. (2006).

The attendance of this program was 100% at every group meeting, which means the participants completed both the MBSR program’s sessions and homework assignments. This indicates that the participants showed interest in the program to decrease the perception of stress. One of the factors contributing to the success of the MBSR program was the length of the program, which was shortened to two weeks of mindfulness-based training session, decreasing demands on the nurses who were busy at work and home. However, if the program was implemented in the 4-8 week period I would have a better perception of the outcome of the program. Although the duration of the program was condensed, the results were not considerably dissimilar among the two week or two to four week programs. Carmody and Baer (2009) determined that there was not connection among the conformity rate and the number of class hours. The most important factor was gaining a better participation percentage to perform the method. Therefore, this program was called “A Mindfulness Stress Reduction Program” to decrease the perception of psychiatric stigma and treatment.

Limitations

The limitations of this program included: it is significant to note the sample size of the cohort was quite small; the program failed to show no follow-up with the perceptions development measures of the program outcomes of these studies.
The constraints of this program were lack of a control group and a nonrandomized design. Time limit of the program was compressed.

Recommendations

In the future, there can be a control group in order to compare in use of this intervention. Have a follow up program in 3 weeks to measure their perception and develop measures of the program outcomes of these studies. Use of the same populace across a longer interval of time is recommended. A randomized control trial follow up is suggested three months post-intervention to further research the outcomes of the mindfulness-based stress reduction program and its usefulness to nurses in the psychiatric locked unit. It is further recommended to implement an analysis on the effect of mindfulness on the nurses’ work performance outcomes, as well as on the impact and measurement of patient outcomes after mindfulness-based stress reduction program has been implemented to further support the evidence of its effectiveness. MBSR should be implemented into continuous professional developmental programs at hospitals to decrease the stress and improve positive coping mechanisms of the nursing staff. Moreover, it is recommended to consider implementing mindfulness strategies into the nursing curriculum to train future nurses how to manage stress. This program will be implemented into the hospital’s educational program and has been approved.

Conclusion

The findings of this program showed that a MBSR program can be effective in decreasing the perception of burnout (emotional exhaustion) and in promoting wellness among psychiatric nurses. Therefore, it is recommend to be used regularly to promote a healthy life-work balance among psychiatric nurses and to improve patient outcomes.
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