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The Psychological Impact of COVID-19

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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by

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MS, East Carolina University 1995

BS, East Carolina University, 1993

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Employees from a large government agency were abruptly switched to telework for an extended period of time. There was no plan to address potential psychological stressors associated with the disruption of work-family-life balance that emerged as a result of COVID-19. A knowledge gap in how to support employees was apparent from discussions during team and administrative meetings. The project question explored whether the use of stress first-aid (SFA), an educational program, would enable employees to learn self-care strategies to address stressors in a less protected environment. The purpose of this DNP project was to provide a staff education awareness program in SFA to identify early warning signs of stress reactions to avert a stress injury. The scientific evidence supported education awareness training as an effective strategy to address the gap among healthcare professionals. Survey Monkey collected and analyzed 37 surveys. The summative evaluation found most employees were very satisfied with teleworking and very frustrated with the return to in-person office settings. Employees 50 years and older, married without children, with advanced degrees, and with years of work experience were worried and extremely worried about the psychological impact of COVID-19. Recommendations included integrating SFA as a competency, new employee orientation, and a mentoring program. Other recommendations included training for SFA site champions and providing leadership training in disaster management to prepare for the next epidemic or pandemic. The project's positive social change impact may lead to reduced stress by fostering peer and organizational support, addressing stigma, and changing the culture to provide a safe work environment.

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Dedication

First and foremost, I give God all the honor and glory because through him, anything is possible. My DNP project is dedicated to my husband, Edwin Hudson-Odoi, who sacrificed so much and asked very little as we journeyed down this path together, and my sons, Curtis and Christopher. They never complained even though most of their lives, I was in nursing school. My loving and beautiful family, Tara, Kamari, Kamya, Nyla, Christian, Brielle, Selwyn, Kendra, Mickey, Ariana, Kelcie, Kingston, Cloe, Isaiah, Grace, Cinnamon, Ny 'Kyla, and Whitney. My dear friends, Keisha and Guy. Lastly, for my beloved Mother to whom I made this promise. I know you are smiling from heaven.

Ecclesiastes 3:1-8, "A Time for Everything."

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Section 1: Nature of the Project

Introduction

The COVID-19 pandemic has touched every aspect of life in some way. COVID-19 has ranked among the most devastating viruses in the past 100 years. In March of 2020, COVID-19 wreaked havoc over the United States, forced massive lockdowns, and closed nonessential establishments to mitigate person-to-person transmission of the virus (Xiao et al., 2021). Though the virus does not discriminate, the social determinants of health inequality and health equity have contributed to more severe manifestations of the disease process among African Americans, Latinos or Hispanics, and Native Americans (Abrams & Szefler, 2020; Peretz et al., 2020; Ryan et al., 2020). Healthcare professionals have also been at a higher risk of contracting COVID-19 than the general population. The misinformation released by the Trump Administration, political influencers, and conspiracy theories (Jolley & Patterson, 2020), as well as disbelief in scientific data, created opposition against scientific experts, which has contributed to the spread of an invisible virus and over 600,000 deaths in the United States (Deane et al., 2021; Rutledge, 2020; Worldometer, 2020. These elements have also contributed to xenophobia and coronaphobia (Alradhawi et al., 2020; Arora et al., 2021; Asmundson & Taylor, 20202020).

Two of the distinctive features of COVID-19 compared to previous pandemics have been the prolonged lockdowns and social distancing (Agha, 2020; Sikali, 2020), which have led to social isolation. Social isolation has raised significant concerns relative to the impact on mental wellbeing. The literature has reported an association between

pandemics, epidemics, natural or manufactured disasters, and mental well-being (Makwana, 2019). The long-term impact of COVID-19 on mental well-being may take years to discover.

In the office setting, nurse employees transitioned from in-person office work settings to home office work settings, which created stressors for some employees, including psychological issues, resulting in increased stress and other mental health compromises. As the agency prepared for and transitioned employees back to work in the office, the psychological impact of the COVID-19 pandemic has not dissipated. This DNP project was a web-based staff education program intended to address psychological issues among the agency's employees who transitioned to telework and the perceived stressors that emerged from returning to the workplace. The positive social change impact that this project could provide is a reduction in mental compromise and a fostering of peer support as a pandemic and postpandemic intervention. Further, it could increase the supportive nature of the work environment.

Problem Statement

The COVID-19 pandemic has disrupted the lives of individuals in profound and unprecedented ways (Yi et al., 2020). In addition, the public health strategies imposed to mitigate the transmission of the virus have posed a threat to mental well-being (Simon et al., 2021). Most federal agencies, including the project agency, had telework agreements already in place. Under normal circumstances, they converted from in-person office work settings to at-work settings in the home, with minimal disruptions to the agency or its employees. Despite being equipped for work environment changes, the agency's

employees have faced extraordinary psychological stressors related to COVID-19 and the associated mandate of working from home (see Hadi et al., 2021; Oakman et al., 2020). Psychological stressors include losing a loved one or colleague to COVID-19, navigating home school schedules, locating childcare resources, financial hardship, food insecurities, limited supplies of personal protective equipment, and cleaning supplies (Oakman et al., 2020). In addition, the loss of internet connectivity, work-life boundaries, social interaction, isolation, sleep deprivation, and pandemic fatigue have led to psychological stressors (Queen & Harding, 2020). If untreated, emotional distress, self-medicating, increased alcohol consumption, or substance abuse could lead to depression and suicide (Carnevale & Hatak, 2020; Reger et al., 2020; Sikali, 2020; Toniolo-Barrios & Pit, 2021; Usher et al., 2020).

The contemplation of a prepandemic work setting might reduce psychological stressors among some employees. Still, additional stressors might arise due to prior preexisting health conditions. The transition may be problematic for employees with preexisting conditions because they are more vulnerable than the general population and experience more severe complications of COVID-19. In addition, women are more likely than men in the agency to be responsible for the care of their children, and, with the return to work, might find locating childcare problematic after adjusting to a work-from-home environment. Finally, the psychological stressors faced during the pandemic might aggravate the perceived stressors associated with returning to an office setting. This project could educate the agency's employees on first aid stress interventions to mitigate stress in the workplace.

The local relevance of the need to address the problem is the safety and health of the agency's employees. Based on the results from a company survey conducted to assist company administrators in planning the transition back to the office setting, more than half of the employees who transitioned to telework were confident in the leadership to bring them back safely. The greatest challenge to the agency was how to best support employees who continued to be impacted by psychological stressors related to the workplace. The managerial team identified that the agency was not equipped to support these unique psychological stressors and identified that organizational team members might also be struggling with the same issues. This doctoral project holds significance for nursing practice because it can address potential psychological issues, mitigate a worsening of mental well-being, and be applied in other settings for those who could benefit from this project's findings.

Purpose Statement

Upon transitioning from home, agency employees who transitioned to telework began experiencing stress and other psychological triggers and early warning signs and symptoms of mental health compromise. The purpose of the DNP project was to provide a staff education awareness program in stress first aid awareness to identify early warning signs of stress reactions intended to avert a stress injury. The practice-focused question was as follows: Will a staff education program educate the agency's employees about an evidence-based strategy to address psychological stressors that emerged after transitioning to working at home?

By educating the agency's staff on stress first aid interventions, this DNP educational project can help prepare employees with techniques to reduce stress and foster peer support as they continue to work from home or transition back to working in the office setting. With the project focus in mind, this DNP project addressed the current gap in practice.

Nature of the Doctoral Project

The nature of the doctoral project was to obtain the best possible available evidence that supported the psychological impact of COVID-19. I used Walden University's library to search multiple databases, such as Nursing, the Cumulative Index to Nursing and Allied Health (CINAHL) plus peer-reviewed literature related to nursing and allied health, The Cochrane Library collection of evidence-based systematic and meta-analyses related to clinical treatment, MEDLINE National Library of Medicine, and EBSCO databases for complete text resources. I expanded the search for evidence to Google, Google Scholar, and Safari search engines because psychological stressors had not been widely studied compared to physical stressors among healthcare professionals. Nursing Reference Center Plus housed the best evidence-based resources designed by nurses for nurses. The PsycINFO database provided social and behavioral health resources, the Centers for Disease Control and Prevention, and the Community Preventive Services to gain access to systematic reviews related to programs and policies that improved health and diseases. Because COVID-19 was a new virus, the search was limited to 2019- to the present. In addition, I referred to articles within the past 5 years for historical evidence related to past pandemics, epidemics, and natural disasters. The

purpose of the DNP project was to provide a staff education awareness program in stress first aid awareness to identify early warning signs of stress reactions to avert a stress injury.

Significance

Traumatic stress has extended beyond pandemics, epidemics, and natural disasters. The long-term consequences among past survivors included work-related stressors, anxiety, depression, unhealthy behaviors, exacerbation of preexisting mental disorders, and suicide (Luo et al., 2020; McAlonan et al., 2007; Mills et al., 2006; Pollard et al., 2020). The long-term psychological consequences are significant to the agency's employees and their families, colleagues, society, and public health (see Maunder et al., 2008; McAlonan et al., 2007; Mills et al., 2006; Pollard et al., 2020).

Prepandemic, the agency's employees in the practice setting worked in a fast-paced, high-stress environment. Factoring in the psychological stressors related to COVID-19, employees might start to display signs and symptoms of stress in their job performance, poor productivity, absenteeism, anxiety, and depression. Their coping mechanisms could diminish into a state of complete exhaustion and burnout (Selye, 1946). The intended contribution for this DNP project is to address early warning signs and symptoms of mental compromise and foster peer support. The DNP project is transferable to the clinical or nonclinical practice area.

Summary

Section 1 provided a brief introduction to the topic/problem, the nature of the DNP doctoral project, and the potential positive social change implications of the doctoral project. The project purpose and statements are included in this section.

Section 2 will provide the background and context for the project. Theories and concepts and a review of the literature will also be provided, and roles, definitions, and motivation for the project will be further discussed.

Section 2: Background and Context

Introduction

The practice problem was the psychological impact of COVID-19 among agency employees who transitioned to mandatory work in the home setting because of COVID-19 and the perceived stressors of returning to the office setting. The practice-focused question was as follows: Will a staff education program educate the agency employees about an evidence-based strategy to address psychological stressors that emerged after working at home? By educating the agency staff on stress first aid interventions, this DNP educational project can assist the agency employees with techniques to reduce stress and foster peer support as they continue to work from home or transition back to working in the office setting. With the project focus in mind, this DNP project addressed the current gap in practice.

Concepts, Models, and Theories

I used the stress first aid (SFA) framework to support this DNP project. Dr. Patricia Watson from the Department of Veterans Affairs developed and implemented SFA at the National Center for Posttraumatic Stress Disorders for military personnel to address stress Watson & Westphal, 2020). First responders, law enforcement, and healthcare professionals have adapted SFA to manage psychological stress faced each day. SFA provides a framework to assist employees and their peers in visually identifying zones of stress, specifically the orange and red, to improve early interventions to stressors while working in the home or office settings (Watson, 2021a; Watson, 2021b; Watson & Westphal, 2020).

There are three principles of the SFA. These principles are individual stress experiences, four zones of stress, and seven essential responses to stress. The stress continuum model (SCM) is the central component of the SFA stimulated by one or multiple stressors relatable to a threat to life, loss or grief, inner conflict, and wear and tear. The spectrum of four colors increases in severity from healthy to debilitating. Green represents wellness and optimality. Yellow means caution because early signs and symptoms of stress are notable and self-limiting. Finally, the orange and red colors represent a prolonged combination of the four stressors capable of producing moderate to severe signs and symptoms of injury and illness, placing the employee at risk for a negative outcome. Appendix B depicts the components of the SFA (see Watson & Westphal, 2020).2020).

Inherent in the SFA are the seven essential Cs. The essentials cover and calm could be interchangeable by bringing things into perspective and protecting or finding a mantra to reduce stress. The essential connect engages an individual with resources of support or social connectedness. Competence is a sense of self-efficacy and the ability to handle the stressor. Confidence could be viewed as having faith, hopefulness, or feeling a sense of optimism. Finally, check and coordinate are in a continuous motion along the spectrum and help to close a gap by being abridge for employees seek mental health services, such as EAPs (Hobfoll et al., 2007Watson, 2020a).

Relevance to Nursing Practice

The American Nurses Association (ANA; 2020) defined a disaster as "any event, caused by natural forces, by the physical failure of machinery, or infrastructure systems

or by the conduct of people that resulted in a significant disruption to the health and safety of the community or segment thereof, or to the nation" (as cited in Shinner & Africa, 2021. The ANA (2020) surveyed 32,000 nurses and found that 86% of nurses feared returning to work, 36% had been exposed and cared for COVID-19 patients without adequate personal protective equipment (PPE), and 11% were confident in being work-ready to care for COVID-19 patients. The primary concerns were personal and family safety, lack of training in PPE in caring for COVID-19 patients, and the lack of supplies and equipment. As a result, some nurses left the nursing profession in fear of safety for themselves, family, or the death of colleagues, and the multitude of COVID-19 related deaths (ANA, 2020). Over 3,600 healthcare workers have died due to COVID-19 related deaths (Spencer, 2020; Zuraw, 2020).

There has been a tremendous amount of mental stress, anxiety, and depression among nurses (Fernandez et al., 2020; Jahan et al., 2021). The fear of contracting COVID-19 and transmitting the virus to family members, social isolation, stigma, moral injury, discrimination (Bagcchi, 2020; Bhattacharya et al., 2020), working longer hours with severe infectious patients, navigating home school schedules, inadequate PPE, and a lack of experience in disaster management training are antecedents to negative behaviors (Aharon et al., 2020; Oakman et al., 2020). Negative consequences could lead to suicide (Lai et al. 2020; Oakman et al., 2020; Rahman & Plummer, 2020). The significant causes of healthcare workers' suicide are the fear of contracting COVID-19, work-related psychological stressors, and anxiety of transmission (Jahan et al., 2021).

From March 2020 to June 2020, six nurses died by suicide globally. The fourth reported nurse suicide was a male nurse who volunteered to work in New York. Colleagues said the nurse had grown more fearful and struggled mentally from trauma, isolation, and opioid addiction (Rahman & Plummer, 2020). The day before his death, the nurse's face shield fell, and he was splashed in the face while intubating his patient (Rahman & Plummer). This doctoral project holds significance for nursing practice because it addresses the identified psychological issues, mitigates a worsening of mental well-being, and is available for others who could benefit from this project to review.

According to Davidson et al. (2020), a hallmark study reported that female nurse suicide rates (11.97/100,000) were far more significant than their counterparts in the general population (7.58/100,000; $p < 0.001$). The researchers also reported that the rate of male nurse suicides was more significant than males in the general population. The study's findings were prepandemic, which supported an even greater need for organizations to address work-related stressors that have contributed to the psychological factors that lead to negative consequences, such as depression and suicide, among healthcare professionals, specifically female nurses.

Mental health has reached epidemic portions in the United States. Before the pandemic, the rate of suicides among healthcare professionals, specifically female nurses, had increased (John et al., 2020). The SFA is relevant to nursing because the framework guides early detection in a change in mental well-being, rapid response, and recovery to mitigate adverse outcomes, such as depression and suicide. In addition, the SFA fosters peer support in the aftermath of COVID-19 as a long-term strategy in maintaining

wellness and reduces the stigma that hinders agency employees from seeking mental

health services available to them, EAPs (Attridge, 2019; Gorter, 2020).

Psychological Impact

The COVID-19 pandemic is considered the deadliest virus outbreak in the United

States surpassing the number of deaths that occurred during the Spanish Flu of 1918

(Gamillo, 2021). Hamouche (2021) examined historical, psychological impacts and the

relationship to the psychological distress and anxiety among employees during COVID-

19. The purpose of this study was to identify themes and insignificant variables that

potentially lessened or worsened mental health well-being. The researcher found that

healthcare professionals' discernment for personal safety, lack of or overload of COVID-

19 related information, stigma, discrimination, quarantine (Bagcchi, 2020; Banerjee &

Meena, 2021), financial hardship, loss of income, and job security were significant

influences of psychological factors and human factors behaviors. In addition, modifying

characteristics, such as individual, organizational, and institutional, directly impacted

mental health well-being among employees returning to work during a pandemic.

However, Hamouche asserted that future research was needed to examine the relationship

between human behavior and the psychological effects. Mental well-being is a

component in creating a safe and healthy work environment for employees returning to

work during a pandemic (Hamouche, 2021).

Employers worldwide recognize there is a gap of knowledge in how to establish a

safe and healthy work culture that supports the mental well-being of healthcare

professionals (Attridge, 2019; Goetel, 2018; Teskin et al., 2020). Khajuria et al. (2021)

conducted the first international cross-sectional study to determine if work-related

stressors were associated with mental well-being among 2,527 healthcare professionals in

41 countries. The researchers found commonalities identified in their findings that

supported previous studies conducted among Chinese and South Asian healthcare

professionals. China ($n = 1,213$; 48%), the United Kingdom ($n = 891$; 35.3%), and the

United States ($n = 252$; 10%) composed 93.3% of the participants. The researchers

further revealed that the majority (80%) of the participants were female. Approximately

50% of the participants were younger, ranging in age from 26 to 40 years. In comparison,

there were more nurses than doctors and allied healthcare professionals. Overall, the

findings in this study also support similar evidence that young female nurses and nurses

with children ranked among the higher at-risk for mental compromise and depression

(Brandford & Reed, 2016; Salari et al., 2020).

Devastation associated with pandemics, epidemics, and natural or manmade

disasters evokes indistinguishable psychological stressors, such as fear, worry, and

anxiety, that can lead to negative consequences, depression, and in some individuals

suicide (Carnevale & Hatak, 2020; Hidaka et al., 2021; Queen & Harding, 2020; Reger et

al., 2020; Sikali, 2020; Toniolo-Barrios & Pitt, 2021; Usher et al., 2020). Mukhtar (2020)

found the unpredictability and uncertainty of COVID-19 exerted widespread negativity

on the psychological well-being of individuals in the community, society, and nation.

The focus of COVID-19 had been mainly on the transmission and development of the

vaccine. Mukhtar recommended more studies that influence psychological and human

behavior, such as coronaphobia, negative consequences, such as isolation, alcohol and

substance abuse, domestic violence, stigma, discrimination, xenophobia, and nosophobia.

The findings in this study give support to previous evidence reported in the literature;

however, a deeper dive into the triggers that invert human behavior may lend to

identifying strategies to counteract human behaviors associated with negative

consequences.

Phobias fueled by misinformation can significantly alter human behaviors, lead to

an ethical dilemma between public health and human rights, and violence (Banerjee &

Meena, 2021; Matta et al., 2020; Rothstein, 2020; Upshur, 2003. Taylor et al. (2020)

stated that the psychological impact of COVID-19 would not be clearly understood and

would linger for years beyond the eradication of the disease. Taylor et al. declared

specific variables linked to pandemics, such as fear, uncertainty, perceived threat, worry,

anxiety, and proneness. Taylor et al. explained that the unknown of COVID-19 could

exert an abnormal and extreme manifestation of fear among individuals until they begin

to believe they had COVID-related symptoms without cause (Arora et al., 2020;

Asmundson & Taylor, 2020). A better understanding of fear and discrimination could

help identify evidence-based strategies to prevent coronaphobia (Taylor et al., 2020).

Healthcare Professionals and Suicide

Female nurses are at a higher risk for suicide than female doctors and the general

population, yet there are numerous research studies related to physicians and patient

suicides and very limited nursing studies (Hawton & Vislisel, 2010; Katz,1983; Nguyen

et al., 2020; Rahman & Plummer, 2020; Ford, 2021). Davidson et al. (2020) examined

the incidence of suicide, the relationship of social and mental risk factors, and the method

of choice among 1,824 nurses and 152,495 nonnurse suicides from 2005 to 2016. The study revealed female nurses compared to male nurses' risk of suicide was higher, and nurse suicide rates were 1.4% higher than in the general population (Davidson et al., 2020). According to the Laura Hyde Foundation (2021), from April 2020 to April 2021, more than 220 nurses in the United Kingdom attempted suicide (as cited in Ford, 2021). Davis (2021) reported that 85% of the total of nurses globally were female. When compared to female physicians, Davis reported that 70% of nurses were more likely to die by suicide. In addition, the rate of female nurses' suicide was twice the number of the general population (Davidson et al., 2020). Benzodiazepines and opioids were the methods of choice female nurses used to commit suicide (Davidson et al., 2020). The researchers recommended strategies to quickly identify impaired nurses with substance abuse and provide available resources (Manthey, 2018) as well as health promotion programs that address work-related stressors healthcare professionals encountered (Davidson et al., 2020).

The Lorna Breen Health Care Provider Protection Act of 2022, named after the physician who committed suicide provides healthcare professionals the mental health resources, training, and programs to address the work-related stressors that can lead to depression, substance abuse, total exhaustion, burnout, and suicide. (Guille, 2021; Manthey, 2018) investigated the hallmark study conducted by Davidson et al. (2020). The author focused on two major contributing factors impactful to nurse suicide: work-related stress and mental compromise. Based on the two contributing factors identified in Davidson et al.'s study, Guille recommended a three-tier integrative approach method as

a framework to address work-related stressors and mental health compromise. The first tier in the framework is to develop primary prevention, such as health promotion and employee wellness programs. The second tier is to develop strategies that identify nurses at-risk for mental health compromise and reduce stigma and discrimination (Hanisch et al., 2021). The third tier is to create focused gender-specific targets that address the stressor independently (Davidson et al., 2020; Guille, 2021). Female nurses comprise approximately 88% of the nurse workforce and have unique needs that potentially increase work-related stressors that lead to negative consequences. In addition, female nurses are twice as likely to commit suicide compared to the female population (Davidson et al., 2020; Guille, 2021). These prepandemic findings supported the overall urgent need to address the unique mental health needs of the female population.

As the number of hospitalizations and deaths increased, fear and uncertainty followed (Bhattacharyna et al., 2020) which placed healthcare professionals under tremendous pressure. Rahman and Plummer (2020) conducted a retrospective analysis to identify COVID-19 related factors among six critical care nurses aged 20 to 49 years employed in hospital settings that committed suicide. They worked with the most severe patients or were exposed, contracted, or quarantined because of COVID-19. Of the six nurses, two had volunteered during the acute stages of COVID-19, and the remaining four had been employees of the facilities. The lack of disaster management and critical life-saving equipment, PPE, shortages of staff, and long hours with increased workloads of very ill patients compounded with fear of transmitting and contracting the virus to family members, lack of organizational mental health support, social support, and

training (Aharon et al., 2020). The factors identified in this study added additional
support to previous evidence that shared commonalities. The researchers suggested
interprofessional collaborative teams to strategize new nursing models and work practices
that addressed emotional distress that could lead to suicide. In addition, the researchers
emphasized that nursing leaders and managers are in an optimal position to bring about a
change in practice that supports mental well-being (Shingler-Nace, 2020). The lessons
learned from previous pandemics, epidemics, and natural or artificial disasters could
effectively assist organizations in developing and implementing evidence-based disaster
management programs to support mental well-being (Hidaka et al., 2020; Matta et al.,
2020).

Work in the Home Settings During COVID-19

Teleworking during the pandemic for some employees was met with increased
physical and emotional job demands and family-life demands due to the abrupt
lockdowns and massive closures of schools and childcare responsibilities (Pulido-Martos
et al., 2021). Galanti et al. (2021) used the jobs demand-resources model (2001) as a
theoretical framework to guide a cross-sectional online questionnaire study that examined
209 employees working in the home during the pandemic. The employees responded to
"family-work conflict, social isolation, distracting environment, job autonomy, and self-
leadership and whether these variables influenced job productivity, work engagement,
and stress" (Galanti et al., 2021, p. e426). The researchers' findings were like other
studies that reported that navigating family-work life and social isolation were among the
two most impactful stressors among employees working in the home during the

pandemic. In addition, flexibility in work schedules and self-discipline were not impactful (Galanti et al., 2021).

Gender gaps in the workplace have been an ongoing issue and the COVID-19 pandemic helped to expose the inequalities and challenges women continue to face. Oakman et al. (2020) conducted a systematic review of articles from 2007 to May 2020 to identify themes or patterns among employees' mental and physical well-being who worked in the home, and whether there was any difference in the gender of the employee. Out of thousands of articles, 23 papers met the selection criteria established by the two independent researchers. Oakman et al. stated 10 health outcomes, "pain, the self-reported status of health, safety, well-being, stress, depression, fatigue, quality of life, strain, and happiness" (p. 1), were reported in the literature reviewed. Seven of the 10 health outcomes identified by the researchers greatly depended upon the level of organizational support, peer support, social support, and family-work disturbances. Summarily to other research studies, the researchers found that women were negatively impacted and were less likely to have positive outcomes while working in the home. Employees would return to in-person office settings in phases. However, there is a need to adapt or develop new work in the home policies that address work boundaries with managerial support and training, delineation of roles, peer support, and workload expectations (Oakman et al., 2020).

Telework agreements have allowed organizations to continue work processes while allowing employees the flexibility to work from home 3-4 days a week depending on their tour of duty; however, some employees preferred an in-person office setting as

required by their organizations. Shao et al. (2021a) used the social-ecological perspective as their framework. They speculated whether 127 Chinese employees decided to work in the home setting or return to an in-person office setting based on the stressors encountered the day prior. Family-work-life balance was a driving force in an employee changing work locations. The findings showed that if there was an increase in work and family stress, the employee would return to the office setting the next day. If the employee experienced more work-related stressors in the office, they would likely work in the home the following day. Technology and location were essential influencers in making work decisions. Shao et al. recommended a deeper dive into psychological stress.

A large number of employees who transitioned to telework because of COVID-19 believed their job performance and family-work-life balances improved (Parker et al., 2020). Wang et al. (2020a) conducted mixed-method studies to examine three categories among 522 Chinese workers who transitioned from in-person work settings to homework settings during the acute phase of COVID-19. The categories included individual work challenges, work characteristics that impacted work challenges, and individual differences among participants. First, the researchers distinguished four significant work challenges: navigating family, home, and work responsibilities; communication issues; work delays or motivation; and social connectedness and support among the participants (Wang et al.). Secondly, they found that the four work characteristics contributed to the work challenges, such as having a social support system, flexibility in schedules, continuous observation, and the amount of work to complete (Wang et al.). The third

finding related to the self-discipline of the participant (Wang et al.). The second study

occurred during the pandemic. The researchers found that work characteristics

contributed to work challenges, job performance, well-being, and work experiences. In

addition, employees with a sound social support system experienced minor challenges.

Autonomy in flexible scheduling contributed to social isolation. Continuous observation

and work contributed to the increased family, home, and work disturbances, and the

amount of work also contributed to delays and motivation (Wang et al., 2020).

Working from the home during COVID-19 provided a safe work environment but

has raised concerns for mental well-being die because of the prolonged lockdowns and

social distancing. Xiao et al. (2021) examined physical and mental well-being among

employees working in the home during COVID-19. An anonymous online questionnaire

collected data from April 24, 2020, to June 11, 2020. Out of 1,409 responses received,

91 did not meet the inclusion criteria, and 330 were less than 25% completed bringing the

sample to 988. There were four categories, lifestyle and home environment, occupational

environment, home office environment, and physical and mental well-being. Participants

who adjusted their work environment and scheduled work hours around family and

household responsibilities showed fewer physical and psychological well-being stressors.

The findings revealed two-thirds (64.8%) of the participants with a new physical health

condition and 41.7% with two or more physical health conditions. Three-fourths (73.6%)

of the participants reported the emergence of new mental well-being issues, and 55.1%

two or more mental well-being issues. In addition, 18.5% developed a new mental health

issue, and 26.4% had no mental well-being issues. A significant finding was female

participants with salaries under 100,000 dollars and participants in lower-income

brackets experienced new or two or more well-being issues compared to the male

participants. The conclusions of these studies were comparable with other studies related

to lockdowns, social distancing, restrictive movements, and work-life imbalances

correlated with a decline in physical fitness activities, physical and mental well-being.

Females with newborns, small children, or who lived with a teenager showed increased

anxiety and stress. This study provided target areas, such as new mental health

disturbances, experiencing mental health issues resulting from the virus, to promote and

improve physical and psychological well-being.

Education and Training

Peer support groups are being recognized as an extremely useful evidence-based

intervention in addressing organizational support (Jadwiaiak, 2020). Albott et al. (2020)

developed the psychological resilience intervention (PRI) program in response to the

unprecedented attack of the COVID-19 pandemic and psychological work-related

stressors. The battle buddy's system was developed by the United States Army as a

strategy to reduce the number of service member suicides among the ranks. Level I check

and balance buddy system of support among to check in on one another and help their

buddy experiencing a crisis and the sequela to reduce stigma. In addition, the PRI

employs a mental health provider on-site that can provide support and defer to the

appropriated mental health services if needed. The purpose of the project was to decrease

the number of suicides among its ranks. As digital technology continues to advance, a

digital buddy system can close the gap in how to support the mental well-being of healthcare professionals (Anadalibi & Flood, 2021).

Evidence-based digital technology can close the gap of knowledge in how an organization could support mental well-being thus decreasing the stigma that hinders healthcare professionals from seeking mental healthcare services, such as employee assistance programs (American Psychological Association, 2022; Attridge, 2019; Makwana, 2019; Milot, 2019). Blake et al. (2020) utilized the Agile methodology to build a digital educational package that supported the mental well-being of healthcare professionals in the United Kingdom (UK). The free digital application provided guidance and steps for team leaders or their designees to create a safe and healthy culture, psychological first aid techniques, and interventions to foster peer and family support and coping mechanisms. Healthcare professionals could also assess expert mental health services and public health, and other available resources. Blake et al. (2020) reported the digital package was accessed more than 17,633 times within a week. The researchers emphasized the significance of reaching healthcare professionals with COVID-19 related training and how to cope with the psychological impact that would linger during and beyond the pandemic. E-learning had been successful in distance learning for universities. It is an approach capable of reaching many employees with consistent training and information with flexibility and different modalities.

Educational awareness and training are strategies reported in the literature to mitigate psychological distress, especially among nonclinical healthcare professionals (Tan et al., 2020). Maunder et al. (2008) explained two evidence-based approaches to

reduce stress and foster individual and organizational resilience among healthcare professionals. Folkman and Geer's (2000) framework could guide a sequential process, such as a stressful event, appraisal, coping, and outcome to reduce emotional distress. Emotions are individual and healthcare professionals with years of experience and training were more likely than not to be affected by increased psychological stressors. Psychological first aid (PFA) was the second approach and was an evidence-based training to assist healthcare professionals in coping with trauma. PFA educational training could reduce stress caused by traumatic experiences and fosters trust, peer support, and social connectedness to reduce isolation and stigma. Maunder et al. (2008) further described the significance of organizational support and organizational justice in building and maintaining employee resilience. Decisional justice encompassed fairness and consistency in the judgment of supervisors or corporate leaders. Relational justice took into consideration employees' views without bias. Healthcare professionals must sometimes work in unfamiliar surroundings. Insufficient training could be detrimental for healthcare professionals.

COVID-19 did not take the United States by surprise; instead, the United States was unprepared for the pandemic, despite having a pandemic playbook created after the Ebola outbreak (Knight, 2020). Shanafelt et al. (2020b) discussed the need to address psychological factors associated with pandemics unique to healthcare professionals. The researchers conducted eight focus groups during the acute stage of the COVID-19 pandemic to better understand the root cause of anxiety. Sixty-nine healthcare professionals participated in the focus groups that produced three primary concerns, the

uncertainty of COVID-19, leadership engagement and support, and available resources to benefit the participants. Shanafelt et al. generated eight psychological factors from the three major concerns derived from the focus groups. The lack of PPE, the risk of exposure and transmission to family members, the availability of rapid COVID-19 testing, provisions of the organization for meeting basic human needs of exposed employees and their families, childcare needs, the ability to meet personal and family responsibilities, portable healthcare coverage from one duty station to another to meet the needs of the facility, and accurate information and clear lines of communication with organizational leaders (Shanafelt et al., 2020). Healthcare professionals need five essential components from their employers "hear me, protect me, prepare me, support me, and care for me" (p. 2134). As a result of the five components, the researchers developed and submitted a visual tool to the leadership of the organization called *the Request from Health Care Professionals to Their Organization During the Coronavirus Disease 2019 Pandemic* that described the main key points of each component with possible solutions that addressed the mental well-being of its employees

Local Background and Context

The agency was in Washington, DC. Most employees commuted from locations near their homes to work two or three times a week upon very crowded public transportation. In March 2020, the uncertainty in the transmission of COVID-19 forced a mandatory transformation of work processes to work in the home setting. Although the practice setting was equipped to transition quickly with minimal disruption, the general population had unique psychological challenges. For example, some employees faced the

loss and grief of a parent, family member, friend, and colleague. In addition, the EAP had not digitalized, creating a gap in mental health counseling through the organization. Besides, the management team had not received the necessary disaster management training to support the unique psychological stressors associated with a pandemic. Another aspect was the agency leaders themselves might have also struggled with similar stressors (Shanafelt et al., 2020).

The prolonged lockdowns and social distancing distinguished COVID-19 apart from previous pandemics or epidemics. Pandemic fatigue and unvaccinated agency employees increased fear, anxiety, and stress as employees prepared to return to in-person office settings. The Department of Veterans Affairs led the charge in requiring mandatory vaccinations for all frontline healthcare professionals. Currently, the agency encouraged but not mandated vaccination. Though the practice setting has been transparent and informative about COVID-19, there was a gap in motivating agency employees to become fully vaccinated. In addition, the transition from work in the home setting to an in-person environment posed difficulties for some agency employees, specifically among women, those in the higher-at-risk or lived with an individual in the higher-at-risk categories, and employees with a mental health disorder.

Role of the DNP Student

My professional context and relationship to the doctoral project where I am a Healthcare System Specialist in the practice setting. My role was to develop, implement, and evaluate the educational program based on SFA. In addition, my role was to gain the support of stakeholders that supported a staff education program. Just as important was to

identify the adopters who needed more information and adopters that were reluctant. I was responsible for securing a practice setting and obtaining a written letter of support.

The DNP Doctoral Project Checklist served as a guide for the written document. In addition, Walden University's Staff Education Manual (2018) process provided the framework for planning, development, implementation, and evaluation for this DNP project. The role of this DNP student was to identify the gap in practice. Conducting a thorough literature review allowed me to obtain the best available evidence that supported the identified gap. Upon the successful completion of the DNP Proposal, I sought IRB approval. Once approved, I scheduled a meeting with the executive leader to provide a timeline, objectives, and goals.

My motivation for this DNP project was understanding COVID-19 created knowledge gaps in nursing. Before the pandemic, my focus had been on female Veterans' suicides. As COVID-19 placed us all in dismay, I changed my DNP project to the psychological impact this deadly virus would leave, specifically among the female population, healthcare professionals, and organizations to include this non-clinical practice setting. The prolonged lockdowns and social distancing have contributed to professional isolation, social isolation, and pandemic fatigue. With the closure of federal agencies, employees were left without Employee Assistance Programs (EAPs) because they had not yet digitalized. This DNP project addressed how to support psychological stressors individually and at the local agency level in EAP absence during a pandemic and beyond. A healthy and safe work environment included strategies to preserve their

employees' mental well-being. The translation of evidence into practice would potentially

provide and advance nursing and be beneficial and available for others to implement.

      In my current role, the long-term psychological impact of invisible wounds

related to combat warfare has led to negative consequences. As described to our current

state and COVID-19, instead of fighting boots on the ground, healthcare professionals to

include this agency employees, have fought socio-political antagonists enhanced by

misinformation through media coverage that produced unique psychological stressors

(Banerjee & Meena, 2021; Biswas et al., 2021; Garfin et al., 2020). This DNP project

potentially will contribute to the advancement of the nursing profession to close the

knowledge gap in how to address the impact of psychological the COVID-19 pandemic

and beyond.

Role of the Project Team

      During monthly administrative team meetings, team members identified and

discussed the psychological stressors that employees who transitioned to working from

home were experiencing. During these meetings, the team also discussed the agency's

inability to provide the support employees working from home required because the

current employee assistance program (EAP) was a face-to-face program that did not

include a virtual component. Further discussion with colleagues and the associate

director confirmed the practice gap that these psychological issues presented and the need

to address this gap in practice. In meeting with the agency's executive leader, they

recognized that this DNP staff education project aligned with the agency's mission and,

therefore, could address the existing gap in practice.

After gaining support from colleagues, the associate director, and the director, I met with the executive leader (EL) of the practice setting via Microsoft Teams. The EL gave verbal permission, followed by a formal written approval to support this DNP project. The DNP committee guided the writing process, evaluation of the DNP project, IRB, and provided feedback to the student.

Summary

The EAP was an excellent organizational-level intervention but remained unavailable because it had not become virtual Gorter, 2020). The SFA was an evidence-based framework successfully implemented among the armed services, first responders, and law enforcement agencies. By educating the agency's employees, this DNP project would assist in stress management and foster peer support. Section 3 will discuss the collection and analysis of the evidence collected following the implementation of the SFA program.

Section 3: Collection and Analysis of Evidence

Introduction

Walden University Library was the primary source for gathering English-language peer-reviewed worldwide evidence for the literature matrix depicted in Appendix A. Healthcare workers have experienced unprecedented psychological stressors related to COVID-19 and the inability to satisfy basic human needs (Dahlke et al., 2021; Matias et al., 2020; Ryan et al., 2020; Suh et al., 2020; Van Bravel et al., 2020). The COVID-19 vaccines have been beneficial in decreasing severe manifestations of the virus. However, the Delta variant and reduction in vaccination uptake have increased. As a result, federal agencies, including the project site, are preparing to reopen and transition employees back into an in-person office setting. However, the transition might not be as welcoming among employees at a higher risk for severe COVID-19 related complications or death.

Practice-Focused Question

The practice-focused question was as follows: Will a staff education program educate the agency's employees about an evidence-based strategy to address psychological stressors that emerged after transitioning to working at home? The purpose of this DNP project was to provide a staff education awareness program in SFA awareness to identify early warning signs of stress reactions intended to avert a stress injury.

The operational definition for work in the home setting is often interchangeable with remote workers, telework, or telecommute. The terms *remote worker* and *telework*

are not found in the Merriam-Webster online dictionary. Remote working offers an alternative to work at another destination with telecommuting capability (Cambridge Dictionary, n.d.). Telework usually occurs in the employee's home. Telecommute can be defined as "to work at home by the use of an electronic linkup with a central office" (Merriam-Webster, n.d.)

Sources of Evidence

I used the Nursing Research page to search Medline, CINAHL, Psych Info, Soc Index, and Science Direct. I also used Google, Google Scholar, and Safari search engines to gather the best available evidence for this new virus. Key search words used for the search were *covid** or *pandemic* or *epidemic, nurse** or *health care professionals* or *hospital staff*, or *psychological factors,* which populated 410 relevant results. The key terms *isolation* or *loneliness* or *exclusion* or *depression* returned 158 results to narrow the literature search. After adding *staff education*, *staff training*, or *staff development* to the previous search terms, I obtained 102 results. Many studies were rapid systematic reviews and duplications of evidence because of the need to address the knowledge gap as a direct result of the unprecedented trajectory of the COVID-19 pandemic.

Evidence Generated for the Doctoral Project

I developed and generated the posttest items from the educational program curriculum. A copy of the Consent Form was generated to prefill sections that could be completed. The Components of the SFA Model provided a description of the model and how the model could be applied to the intended population (see Appendix B). The SFA Educational Program Curriculum outlined the objectives, key teaching points, and goals

(see Appendix C). For the collection of data, a demographic survey was used to identify

gender, age (years), level of education, marital status, dependents, tenure, and the

number of hours work from home pre-pandemic (see Appendix D).

Participants

The nonrandom sample of volunteer participants was recruited through an

encrypted email. The composition of the sample was healthcare system specialists who

included registered nurses, advanced practice registered nurses, nurse consultants, nurse

leaders, management analysts, and other allied health disciplines (see Table 1). Because

the email was sent to all agency employees, there were no exclusions of participants

from the project survey. The demographic questionnaire delineated the characteristics

among the healthcare professionals. There was no monetary gift for participation in the

staff education program.

Procedures

The executive leader (EL) of the practice setting released an email of support for

the staff educational program to all agency employees. For the purposes of data

collection, I used Survey Monkey, an online data software company. An introductory

email with a description of the staff education program was sent to agency employees

(see Appendix E). If an employee clicked the decline tab, the page would not advance

any further; if an employee wanted to participate in the study, they saw instructions of

how to access the consent form and demographic survey (see Appendix D). In 7

business days, Survey Monkey automatically emailed the date, time, and how to access

the web-based 60-minute staff educational program. Following the staff educational

program, instructions on how to access the posttest (see Appendix F) and a self-certification were administered to the attendees. The participants received 1-hour educational credit that was recorded in the Talent Management System. There were no monetary gifts awarded to the participants.

Protections

Walden University Internal Review Board (IRB) approval #11-09-21-1016408 was obtained prior to the implementation of the staff education program. Prior to implementing the staff education program, informed consent forms were sent. The anonymity of the healthcare professionals and the Privacy Statement in the Consent Form were strictly followed. There were no patients involved in the study. Survey Monkey has worked well for numerous projects to ensure their privacy and confidentiality because the data are protected with enhanced security and encryption.

Analysis and Synthesis

Once the data were collected, Survey Monkey used advanced analysis tools for the data and provided tables and charts. A paired *t* test was used to determine whether there was a statistical difference between the pretest and posttest. The results of the posttest showed whether there was a difference in the responses postintervention. The demographic data were analyzed to provide characteristics of the participants and to determine whether there were themes or patterns in how each participant responded.

Summary

The implementation of the educational program and the evaluation of the program were presented in this section. Section 4 will present the findings and recommendations associated with the processes and outcomes of the Survey Monkey findings.

Section 4: Findings and Recommendations

Introduction

Employees experienced unique psychological triggers, early warning signs, and symptoms of mental health compromise after transitioning to mandatory telework. The EAP was unavailable to employees because it lacked a digital component, thus creating a gap (see Hobfoll et al., 2007; Matthews et al., 2021;). Stigma in the workplace is a significant psychological stressor that hinders healthcare professionals in seeking counseling services (Hamouche, 2021 Hanisch et al., 2016). Leaders and employees identified a practice gap in managing the unique psychological stressors during organizational and team discussions (see Hadi et al., 2021 Oakman et al., 2020). The practice-focused question was as follows: Will a staff education program educate the agency's employees about an evidence-based strategy to address psychological stressors after transitioning to working at home? The purpose of this DNP project was to provide a staff education awareness program in SFA awareness to identify early warning signs of stress reactions to avert a stress injury.

Three literature searches from the Walden University Library narrowed the literature search to 102 articles. Fifty-six duplicate articles, nine dated, and 18 articles were excluded for reasons such as unable to access, written in a foreign language, no intervention, unrelated to the study, and included patients. I used 19 full-text articles that included historical pandemic references to address the practice-focused question. The Literature Review Matrix depicted evidence that supported the practice-focused question among four major topics: the psychological impact of COVID-19, healthcare

professionals and suicides, work in the home during COVID-19, education, and training (see Appendix A).

Nurse leaders are in an optimal position to implement a change in practice. Still, they lacked knowledge of managing employees impacted by those unique psychological stressors that emerged directly from the COVID-19 pandemic and after transitioning to a home office work setting (Rahman & Plummer, 2020). The evidence supported education training, peer support, and organizational support as drivers in building relationships that identified early warning signs and symptoms of mental compromise (Albott et al., 2020; Hadi et al., 2021; Hamouche, 2021; Oakman et al., 2020). The evidence-based training programs, such as mental health first aid, peer support specialist, psychological first aid, and resiliency training, lent support to the practice-focused question (see Albott et al., 2020; Maunder, 2008; Wang et al., 2021).

Findings and Implications

Thirty-seven healthcare professionals were invited to participate in the study. Of the 37 participants, 22 completed the staff education course component. The data analysis of the 22 participants is explained below. Only 15 participants completed the posttest component. In addition, 37 returned the demographic component. Most of the participants were females (92%), were older than 50 years (65%), and had 20 years or more (66%) work history. Most of the participants were married (62%) and White (65%). Of the 37 participants, 71% were nurses, 59% were master-prepared, and another 24% were doctoral-prepared. Table 1 depicts the demographic characteristics of the 37 participants.

Table 1

Demographics Characteristics

Characteristics	Total	Females	Males	Standard Deviation	
Gender	(n=37)	34 (92%)	3 (8%)	0.27	0.00
Age					
35-49 years	(n=13)	12 (35%)	1 (33%)	0.48	0.47
50 years and older	(n=24)	22 (65%)	2 (67%)		
Marital status					
Single	(n=9)	8 (24%)	1 (33%)		
Married	(n=23)	21 (62%)	2 (67%)	1.31	0.47
Divorced	(n=4)	4 (12%)	0 (0%)		
Long term partner	(n=1)	1 (3%)			
Ethnic background					
White	(n=22)	21 (62%)	1 (33%)	1.35	0.00
African American	(n=13)	11 (32%)	2 (67%)		
Asian	(n=1)	1 (3%)			
Bi-racial	(n=1)	1 (3%)			
Children under 18 years					
35-49 years	(n=10)	10 (30%)	0 (0%)	0.46	0.00
50 years and older	(n=0)	0 (0%)			
Highest education					
High school	(n=1)	1 (3%)			1.25
Some college	(n=1)	1 (3%)			
Associate Degree	(n=0)	0 (0%)			
Bachelor's Degree	(n=2)	1 (3%)	1 (33%)		1.18
Master's Degree	(n=22)	21 (62%)	1 (33%)		
Doctorate	(n=9)	8 (24%)	1 (33%)		
Master's Certificate	(n=1)	1 (3.0%)			
Diploma	(n=1)	1 (3%)			
Profession				2.01	2.45
Registered nurse	(n=6)	5 (15%)	1 (3%)		
Advanced practice nurse	(n=1)	1 (3%)			
Nurse consultant	(n=7)	7 (21%)			
Healthcare system	(n=10)	9 (26%)	1 (33%)		
specialist	(n=5)	5 (15%)			
Licensed social worker	(n=0)				
Physician assistant	(n=1)		1 (33%)		
Allied health provider	(n=1)	1 (3%)			
Nurse attorney	(n=1)	1 (3%)			
Administration	(n=1)	1 (3%)			
Research and data analysis	(n=1)	1 (3%)			
Other					
				0.83	0.94
Experience	(n=2)	2 (6%)			
Less than 5 years	(n=2)	1 (3%)	1 (33%)		
6-10 years	(n=8)	8 (25%)			
11-20 years	(n=23)	21 (66%)	2 (67%)		
20 years or more					
Years current employer	(n=17)	14 (41%)	3 (100%)		0.00
Less than 5 years	(n=3)	3 (9%)			
6-10 years	(n=12)	12 (35%)			
11-20 years	(n=5)	5 (15%)			
20 years or more					

Note. Survey Monkey Analysis. General demographic characteristics of the 37

participants in the study.

Reaction, Level 1 of Kirkpatrick's (1996) evaluation, evaluated how the 22

participants perceived the staff education component and its relevance. Of the 22 course

evaluation surveys completed (see Appendix G), most of the participants, 36%, *agreed,*

4/5, and 64% *strongly agreed,* on a 5-point Likert scale. The analyzed data revealed that

the 22 participants were overall satisfied and found the SFA education component

relevant. Table 2 depicts Kirkpatrick's (1996) reaction Level 1 evaluation, and Table 3 is

the summary of the SFA staff education curriculum.

Table 2

Kirkpatrick's (1996) Reaction Level 1 Evaluation SFA Staff Education Curriculum

Reaction Level 1	Strongly disagree 1	Disagree 2	Neither 3	Somewhat agree 4	Strongly agree 5
I was able to relate each of the learning objectives to the learning I achieved.	9% (*n* = 2)	0.00% (*n* = 0)	0.00% (*n* = 0)	41% (*n* = 9)	50% (*n* = 11)
I will be able to immediately apply what I learned.	5% (*n* = 1)	0.00% (*n* = 0)	0.00% (*n* = 0)	57% (*n* = 12)	38% (*n* = 8)
I found the course materials easy to navigate.	5% (*n* = 1)	0.00% (*n* = 0)	9% (*n* = 2)	45% (*n* = 10)	41% (*n* = 9)
My learning was enhanced by the knowledge of the facilitator.	5% (*n* = 1)	0.00% (*n* = 0)	5% (*n* = 1)	14% (*n* = 3)	77% (*n* = 17)
How likely are you to use some or all the knowledge and skills taught in this training in your personal life?	Very likely 0.00% (*n* = 0)	Unlikely 0.00% (*n* = 0)	Neither 0.00% (*n* = 0)	Likely 51% (*n* = 13)	Very likely 41% (*n* = 9)
I was satisfied with the course overall.	Very dissatisfied 0.00% (*n* = 0)	Dissatisfied 0.00% (*n* = 0)	Neither 0.00% (*n* = 0)	Satisfied 36% (*n* = 8)	Very satisfied 64% (*n* = 14)

Note. Adapted from Kirkpatrick (1996) Level 1 (Reaction) Core Evaluation Items.

Preparedness and Emergency Response Learning Centers (PERLC). Public Health

Foundation. Table 2 depicts the analysis of the respondent's perception of the educational

component. Most of the respondents on the Likert scale were 4 *somewhat agree* and 5

strongly agreed.

Table 3

Kirkpatrick's (1996) Reaction Level 1 Summary SFA Staff Education Curriculum

Level 1	Number of respondents	Total number of respondents	Met	Not met

1. Learning objective	20	22	X	N/A
2. Relevancy in emergency	20	21	X	N/A
3. Understandability	19	22	X	N/A
4. Learning enhanced by knowledge of facilitator	20	22	X	N/A
5. Usability	22	22	X	N/A
6. Overall satisfaction	22	22	X	N/A

Note. Adapted Kirkpatrick's (1996) Level 1 (Reaction) Core Evaluation Items.

Preparedness and Emergency Response Learning Centers (PERLC). Public Health

Foundation. Table 3 depicts the analysis of the respondents who reported *somewhat*

agree and *strongly agree* on the Likert scale ranging from 1 = *strongly disagree* to 5 =

strongly agree. The results reported showed that the respondents perceived the learning

activity to be of an overwhelming satisfaction majority.

Of the 22 participants, the analyzed data revealed that 64% *agreed*, 4/5, and 36%

strongly agreed, 5/5, on a 5-point Likert scale that demonstrated that the learning

objectives were met and the participants gained knowledge in how to support the unique

psychological factors incurred while working in the home during the pandemic. Table 4

depicts Kirkpatrick's (1996) Level 2 evaluation of the SFA staff education curriculum.

Table 5 depicts Kirkpatrick's (1996) learning Level 2 summary for SFA staff education

curriculum and indicates that the learning objectives were met. A total value of 50% or

more of the combined rankings *agree* and *strongly agree* knowledge gained.

Table 4

Kirkpatrick's (1996) Level 2 Learning of Evaluation of SFA Staff Education Curriculum

Learning objective	Strongly disagree 1	Disagree 2	Neither 3	Somewhat agree 4	Strongly agree 5

1. Appraise the foundation of SFA.	5% (n=1)	0.00% (n=0)	0.00% (n=0)	55% (n=12)	41% (n=9)
2. Delineate the SCM.	23% (n=5)	9% (n=2)	0.00% (0)	32% (n=7)	36% (n=8)
3. Described the SFA essential seven Cs of stress responses.	5% (n=1)	0.00% (n=0)	5% (n=1)	41% (n=9)	50% (n=11)
4. Appraise the significance of coworker support.	9% (n=2)	0.00% (n= 0)	0.00% (n=0)	18 % (n=4)	73% (n=16)

Note. Adapted Kirkpatrick's (1996) Level 2 (Learning) Core Evaluation Component.

Preparedness and Emergency Response Learning Centers (PERLC). Public Health

Foundation. Table 4 depicts the analysis of the respondents who self-reported *somewhat*

agree and *strongly agree* on the Likert scale ranging from 1 = *strongly disagree* to 5 =

strongly agree. The results reported showed the learning objectives were met.

Table 5

Kirkpatrick's (1996) Level 2 Learning Evaluation Summary of the SFA Staff Education Curriculum

Level 2	Number of respondents	Total number of respondents	Met	Not met
1. Appraise the foundation of SFA.	21	22	X	N/A
Delineate the SCM.	15	22	X	N/A
Described the SFA essential seven Cs of stress responses.	20	22	X	N/A
Appraise the significance of coworker support.	20	22	X	N/A

Note. Table 5 depicts the number of respondents who selected *somewhat agree* and

strongly agree numerators. The total number of respondents represents the total number

of surveys received. A percentage over 50% equals the learning objective was met.

Of the 37 demographic surveys completed, 97% (34) of the participants were very satisfied and satisfied with their current home office work setting, 46% were frustrated in having to return to an office work setting, and 33% chose that nothing would make them feel more comfortable returning to the office. Among the 37 participants, 30% found uncertainty about the future, pandemic fatigue, and social distancing as three major challenges faced while working in the home. With the massive closures and prolonged lockdowns, 80% of participants were worried about the psychological impact of COVID-19, and 94% had psychological support while working in the home. Of the 37 participants, 87% would be upset if wearing a face mask in the office, antibody testing, and contact tracing were required or implemented in the office. Another 16% of the 37 participants opposed temperature checks at all entrances of the practice setting. Lastly, of the 37 participants, 95% were comfortable voicing concerns to their supervisors, 89% were comfortable sharing new ideas and suggestions with their leadership, and 65% would recommend disaster management training for all agency employees. Table 6 depicts the analysis of the 37 participants working in the home office setting during COVID-19.

In summary, pandemic fatigue, comfort level, and different views on safety precautions among the 37 participants could potentially increase or escalate worry, fear, stress, anxiety, stigma, or mask shaming and leave vulnerable individuals at a higher risk (Smith, 2022). The literature reported young women with children, with 5 years or less work experience, and who had annual salaries less than $50,000 to $100,000 were more likely to have a significant psychological impact of COVID-19. I also discovered that of

the 37 participants 50 years and older worried more about the psychological impact of

COVID-19 than participants 49 years old and younger, which differed from some of the

findings reviewed for this study (see Makwana, 2019; Que et al., 2020; Vizheh et al.,

2021; Yildirim et al., 2020). The staff education program will not be implemented until

sometime after my graduation.

Table 6

Working From Home During COVID-19

Questions	Total number (N = 37)	Female (n = 34)	Male (n = 3)	Standard Deviation Female Male		Mean Female	Male
How satisfied are you with your current work from home arrangement?	(N = 36)	(n = 33)	(n = 4)	0.43	0.47	1.15	1.33
	31	29 (88%)	2 (67%)				
	4	3 (9%)	1 (33%)				
Very satisfied	2	1 (33%)	1 (33%)				
Somewhat satisfied	0	0 (0%)	0 (o%)				
Neither satisfied nor dissatisfied	0	0 (0%)	0 (0%)				
Somewhat dissatisfied							
Very dissatisfied							
If given the opportunity; would you continue to work at home?	(N = 36)	(n = 33)	(n = 3)	0.17	0.00	1.03	1.00
Yes		32 (97%)	3 (100%)				
No	(n = 35)	1 (3%)	0				
	(n = 1)						
What were the two biggest challenges you faced while working from home?	(N = 37)	(n = 34)	(n = 3)	6.06	7.82	7.62	5.56
Pandemic fatigue	(n = 4)	4(12%)	0 (0%)				
Uncertainty	(n = 4)	(12%)	0 (0%)				
Social isolation	(n = 3)	3 (9%)	0 (0%)				
Social engagement	(n = 0)	0 (0%)	0 (0%)				
My physical workspace	(n = 1)	1 (3%)	0 (0%)				
Too many distractions	(n = 1)	1 (3%)	1 (3%)				
Internet connectivity	(n = 0)	0 (0%)	0 (0%)				
Childcare	(n = 2)	2 (6%)	0 (0%)				
Prolonged lockdowns	(n = 1)	1 (3%)	0 (0%)				
Working while sick	(n = 1)	1 (3%)	0 (0%)				
Keeping regular schedule	(n = 0)	0 (0%)	0 (0%)				
	(n = 0)	0 (0%)	0 (0%)				
Navigating home school	(n = 2)	1 (3%)	1 (33%)				
Loss and grief	(n = 5)	5 (15%)	0 (%)				
Other	(n = 12)	11 (32%)	1 (33%)				
None of the above							
With the massive closures and prolonged lockdowns, how worried were you about the psychological impact COVID-19 among healthcare professionals?	(N=36)	(n = 33)	(n = 3)	0.85	0.47	2.24	0.47
	(n = 7)	7 (21%)	0 (0%)				
	(n = 13)	13 (39%)	0 (0%)				
Extremely worried	(n = 13)	11 (33%)	2 (67%)				
Very worried	(n = 3)	2 (6%)	1 (33%)				
Somewhat worried	(n = 0)	0 (0%)	0 (0%)				
Not as worried							
Not at all worried							

Questions	Total number (N = 37)	Female (n = 34)	Male (n = 3)	Standard Deviation		Mean	
				Female	Male	Female	Male
Which of the following would you be upset if implemented or required when returning to work in the office?	(N = 31)	(n = 27)	(n = 4)	4.57	4.23	9.28	9.33
Temperature checks	(n = 5)	4 (14%)	1 (50%)				
Closing communal spaces	(n = 4)	4 (14%)	0 (0.0%)				
Clean desk policy	(n = 2)	2 (7%)	0 (0.0%)				
Boxed lunches	(n = 2)	2 (7%)	0 (0.0%)				
Getting a vaccine	(n = 4)	4 (14%)	0 (0.0%)				
Limiting the number of employees in the building	(n = 1)	1 (3%)	0 (0.0%)				
Limiting visitors in the building	(n = 1)	1 (3%)	0 (0.0%)				
Staggering hours/shifts	(n = 7)	6 (21%)	1 (50%)				
Staggering lunchtimes	(n = 4)	4 (14%)	0 (0.0%)				
Wearing a mask in the office	(n = 9)	7 (24%)	2 (100%)				
Nightly deep clean or sanitation	(n = 1)	1 (3%)	0 (0.0%)				
Partitions in between desk	(n = 1)	1 (3%)	0 (0.0%)				
Contact tracing app	(n = 9)	8(28%)	0 (0.0%)				
Antibody testing	(n = 9)	8 (28%)	1 (50%)				
Something else	(n = 7)	7 (24%)	1 (50%)				
	(N = 37)	(n = 34)	(n = 3%)				
How comfortable do you feel voicing your concerns to your supervisor?	(n = 14)	14 (41%)	0 (0.0%)	0.83	0.47	1.79	2.33
	(n = 17)	15 (44%)	2 (67%)				
	(n = 4)	3 (9%)	1 (33%)				
	(n = 2)	2 (6%)	0 (0.0%)				
	(n = 0)	0 (0.0%)	0 (0.0%)				
Extremely comfortable							
Very comfortable							
Somewhat comfortable							
Not so comfortable							
Not at all comfortable							
	(N=37)	(n = 34)	(n = 3)	0.53	0.00	1.32	2.00
Would you recommend disaster management training for all agency employees?	(n = 24)	24 (71%)	0 (0.0%)				
	(n = 9)	9 (26%)	3 (100%)				
	(n = 1)	1 (3%)	0 (0.0%)				
Yes							
No							
Not sure							
	(N=37)	(n=34)	(n=3)	1.11	0.47	2.24	2.33
How comfortable do you feel sharing new ideas and suggestions with your leadership at work?	(n = 10)	10 (29%)	0 (0.0%)				
	(n = 14)	12 (35%)	2 (67%)				
	(n = 9)	8 (24%)	1 (33%)				
	(n = 2)	2 (6%)	0 (0.0%)				
Extremely comfortable	(n = 1)	1 (33%)	0 (0.0%)				
Very comfortable							
Somewhat comfortable							
Not so comfortable							
Not at all comfortable							

Unanticipated Limitations or Outcomes

One unanticipated project limitation was out of the 37 invited participants 2 completed the course evaluation and only 15 the posttest surveys, despite an email reminder. Starr's (2012) editorial revealed not all surveys received are submitted. More than 80 employees joined the scheduled educational training, but some departed early or declined to participate in the study. Question12 from the demographic survey would not allow the participants to choose more than two choices and Question 2 on the course evaluation's ranking order was transposed. Due to transitioning to in-person office settings, permission to proceed with the DNP project was granted but an agency-wide email was not released from the executive leader.

Implications Individual, Community, Institutions, and System

Mental health has often been overlooked in planning a safe work environment (Maulik, 2017). Mental health is a goal of Healthy People 2020 because of the ramifications associated with physical, emotional, and chronic diseases (Health People, 2020). Out of 22 participants, 95% would be able to apply the knowledge gained immediately, 100% were likely to use some or all the knowledge skills learned from the education component, and 100% were satisfied with the course overall. These findings are implications the SFA staff education component closed a gap of knowledge. Of the 37 participants, 65% would recommend disaster management training for all agency employees. However, this was not indicative that SFA is a strategy for all agency employees. Still, its findings can be utilized as a pilot to improve the staff education program.

Potential Implications for Positive Social Change

Positive social change can occur among individuals, the practice setting, and the organization. The positive social change impact that this project could provide is a reduction in mental compromise and foster peer support and organizational support as a pandemic and post-pandemic intervention as the agency move toward a safe work culture.

Recommendations

Mental well-being was often overlooked in the planning of a safe work culture (Bisbey et. al., 2021; Naji et al., 2021). Based on the findings in this study, 100% of the participants, if the opportunity presented, would continue to work in the home, the response to the psychological impact of COVID-19 while working in the home office setting, and the different views regarding the use of face masking and other safety precautions if required or implemented in the office setting to avert an outbreak of the virus raised concerns in how the agency would create a safe work culture and protect the mental well-being of its employees. The literature reported the weight psychological factors had on job performance and stressed organizations take these issues into account in creating or maintaining a safe work environment (Bisbey et al., 2021; Naji et al., 2021). Table 7 lists the recommendations based on the findings in this study.

Table 7

Recommendations Based on the Findings

Recommendations	Suggestions for implementation into practice
To sustain the staff education program	Integrate with Training and Development and the Talent Management System (TMS) as part of the required 40 hours employees must obtain every two. Years, and the new employee cohorts.
To revise Posttest	Revise the posttest questions to be more specific for selecting the best answer.
To establish a peer support group	Peer support allows employees to check in on one another, not just during a crisis, to avoid not having any help or somewhat support.
To adequately train the Managerial team	SFA and the National Center for PTSD have developed a 4-hour training to best support employees' unique psychological stressors after transitioning to a home office work setting. Adequate training will also prepare supervisors for the long-term psychological impact of COVID-19.
To reduce stigma, discrimination, biases, and mask shaming	There are different views among employees about wearing masks in the office setting. However, as part of a safe and healthy work environment, policy changes should include these stressors that can lead to mental compromise.

Note. The recommendations were based on the Posttest, Course Evaluation Survey, and

Demographic Survey findings.

Proposed Secondary Products, Implementation, and Evaluation

The COVID-19 Protection to Ensure Resilient Health Care Workers SFA

Implementation Guide for Site Champions (COVER-HCW). The components of the

COVER-HCW included six steps: (a) Get ready for site champion training, (b) participate

in site champion training, (c) plan for SFA implementation, (d) introduce SFA to selected

teams, (e) provide SFA booster sessions, and (f) engage in COVER-HCW evaluation. Dr.

Watson offered training in a 2-hour video and arranged for Champions to receive two-

hour continuing education (CE) and a 1-hour CE training for health care workers trained

by the site champions. All educational training materials and worksheets to implement SFA site champions are available on RAND in Kiteworks, a secure website for file sharing. A Kiteworks account is required. The videos to prepare for the Champion site visit are on the YouTube channel. Nurses, physicians, pharmacists, psychologists, social workers, and community health workers are eligible for CE credit.

Contribution of the Doctoral Project Team

Working With the Doctoral Project Team

The Doctor Project Team consisted of a Doctor of Nursing Science (DNS) who served as the expert contributor for the project. The expert reviewed and provided feedback for the educational curriculum, post-test, PowerPoint presentation, and evaluation before forwarding the educational contents to the Associate Director for review. The Director completed the final vetting process before forwarding them to the Executive Leader. The Director composed an email with attachments of the Walden University Consent Form for Anonymous Consent, the Demographic Survey, SFA Course Evaluation, and Educational Curriculum for final approval. The Executive Leader granted permission to move forward with the staff education program. The clinical expert was consulted in developing the final recommendations and provided feedback on the study's findings.

Future of DNP Project

The future of the implementation of the project is unknown at this point. Employees were mandated to return to their perspective duty stations in April 2022. The recovery period would take precedence for training in new office policies and the

readjustment of new office setting configurations. The PowerPoint presentation will be made available on the agency website for others to benefit from.

Strengths and Limitations of the Project

Strength of the Project

Stakeholders' support was a strength in the DNP project, specifically, because it aligned with the organization's mission. The SFA framework and instructor's manuals guided the development of the educational components. The staff education manual guided the planning, implementing, and evaluating phases of the project. The virtual setting offered different modalities to allow for more participants. Lastly, the strength of the SFA program, in general, was that several disciplines have implemented the framework among their ranks to address stress in the workplace.

Limitations of the Project

The lack of time to attend the education session or complete the survey due to multiple projects with competing deadlines and motivation to complete the survey were limitations of the project. Of the 37 participants, 22 completed the course evaluation. There were no monetary gifts offered for incentives to participate. The literature reported there is a higher increase in survey participants who received compensation for completion (Kost & de Rosa, 2018). Skipped choices on surveys were uncontrollable. According to Survey Monkey's (2022) website of useful information, social desirability may contribute to whether a participant skipped a question because the perceived sensitive or personal questions could make them unfavorable or social desirability bias.

Future Projects Addressing Similar Topics and Methods

Psychological first aid (PFA) and the mental health first aid (MHFA) Models were similar but based on different principles. PFA was designed as a critical incident approach to help individuals after a traumatic event, such as the devastation of a hurricane or tornado, to mitigate the incident of posttraumatic stress syndrome (Wang et al., 2021b). MHFA aims to bring educational awareness to mental health literacy among individuals at risk of developing a new mental health condition, individuals diagnosed with a new mental health condition, or individuals with preexisting mental health conditions to reduce stress in pregnancy (Morgan et al., 2019).

Section 5: Dissemination Plan

A PowerPoint presentation of the findings and recommendations will be presented to the EL. In addition, the findings, and recommendations will be given to agency employees during the next available administrative monthly meeting. Finally, the SFA PowerPoint presentation will be made available on the agency's website so that others may benefit.

Mental well-being has not been formally addressed in this organization but is significant in creating a safe work culture. May is Mental Health Awareness Month and an opportune time to present the SFA to the agency as part of the Diversity, Equity, and Inclusion committee's activities. Past attendances were well represented among the organization's employees, including the executive and senior leadership.

The DNP project will be published and reviewed by other researchers and students that benefit others. Nursing conferences have served as a strategy to disseminate projects. I have planned to present my project at a later date.

Analysis of Self

As a practitioner, I have acquired competence and confidence due to over 30 years in nursing. From humble beginnings at the lowest level of nursing, as a nursing aide in the newborn nursery, licensed practical nurse, registered nurse, and advanced practice nurse, the knowledge gained has transformed my nursing skills from a novice to becoming an expert in my specialty.

Becoming a Doctoral Candidate and completing a DNP scholarly project is a beautiful achievement but not without heartbreaks and disappointments. As a scholar, I

will never forget my chair reminding me, "I am a talker," meaning I tend to overwrite. Therefore, there is always room for improvement, and something I will need to work on. Becoming a scholar will take time. However, being a project manager of this DNP will be an asset for future projects within the agency because projects and writing are highly regarded. My long-term professional goals are to mentor nursing students, become a professor in a nursing program, and write my first book for publication.

The completion of this DNP project was the final milestone in my nursing career. Personal challenges were unpredicted and caused me to lose focus. Accepting what I could not control was the best solution to move forward. Life-work-school balance was often challenging, and there were a lot of sacrifices. The DNP project meant more to me than just checking off a requirement. I wanted a meaningful project that was practicable, longevity, and cost-effective. While working on the project, I gained a better understanding of SFA and applied its concepts as part of my self-care strategy to move in the direction of the green zone.

Summary

The DNP is an independent scholarly research study that demonstrates critical thinking and academic writing, competence in research and research design, and a contribution directly and indirectly to healthcare (Walden University, 2020). This DNP project aimed to close a gap in knowledge on managing and supporting agency employees who have experienced unique psychological stressors that emerged during the COVID-19 pandemic while they transitioned to telework when there were no organizational-level resources available. The literature supported a gap in administrative

support to address emotional distress among employees. In disaster management, organizations and nurse leaders have tread through unchartered waters and they have been tasked with unique situations resulting from the pandemic. SFA is a practical strategy that anyone can apply for self-care and the care of coworkers.

References

Abrams, E. M., & Szefler, S. J. (2020). COVID-19 and the impact of social determinants of health. *The Lancet, 8*(7), 659-661. https://doi.org/10.1016/S2213-2600(20)30234-4

Agha, S. (2021). Mental well-being and association of the four factors of coping structure mode: A perspective of people living in lockdown during COVID-19. *Ethics, medicine, and public health, 16,*100605. https://doi.org/10.1016/j.jemep.2020.100605

Aharon, A. A., Ruban, R., & Dubovi, I. (2020). Knowledge and information credibility evaluation strategies regarding COVID-19: A cross-sectional study. *Nursing outlook, 69(2021)*, 22-31. https://doi.org/10.1016/j.outlook.2020.09.001

Albott, C. S., Wozniak, J. R., McGlinch, B. P., Wall, M. H., Gold, B. S., & Vinogradov, S. (2020). Battle buddies: Rapid deployment of psychological resilience intervention for healthcare workers during the COVID-19 pandemic. *Anesthesia and analgesia, 13*(*1*), 43-54. https://doi.org/10.1213/ANE.0000000000004912

Alradhaw, M., Shubber, N., Sheppard, J., & Ali, Y. (2020). Effects of the COVID-19 pandemic on mental well-being amongst individuals in society-A letter to the editor on "The socio-economic implications of the coronavirus and COVID-19 pandemic: A review". *International Journal of Surgery (London, England), 78,* 147-148. https://doi.org/10.1016/j.ijsu.2020.04.070

American Nurses Association. (2020). Initial COVID-19 survey. What 32,000 nurses want you to know about treating COVID-19. *Nursingworld.org*

https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/what-you-need -to-know/covid-19survey-results/.

American Psychological Association. (2022, April 27). Considering digital mental health tools for your employees. https://www.apa.org/topics/workplace/digital-mental-health-tools

Andalibi, N., & Flood, M.K. (2021). Consideration in designing digital peer support for mental health: Interview study among users of a digital support system (Buddy project). *JMIR Mental Health, 8(1),* e21819.

https://www.apa.org/topics/workplace/digital-mental-health-tools

Arora, A., Jha, A. K., Alat, P., & Das, S. S. (2020). Understanding coronaphobia. *Asian Journal of Psychiatry, 54*,102384. https://doi.org/10.1016/j.1jp.2020.102384

Asmundson, G., & Taylor. S. (2020). Coronaphobia: Fear and the 2019-nCoV outbreak [Editorial]. *Journal of Anxiety Disorders, 70*(*2020)*, 102196.

https://doi.org/10.1016/j.janxdis.2020.102196

Attridge, M. (2019). A global perspective on promoting workplace mental health and the role of employee assistance programs. *American Journal of Health Promotion, 33(4)*, 622-629.

https://journals.sagepub.com/doi/pdf/10.1177/0890117119838101c

Bagcchi, S. (2020). Stigma during the COVID-19 pandemic. *Lancet infectious diseases, 20(7),* 782. doi:10.1016/S1473-3099(20)30498-9

Banerjee, D., & Meena, K. S. (2021). COVID-19 as an "infodemic" in public health:

Critical role of the social media. *Frontier in public health, 9(610623)*.

https://www.frontiersin, org/articles/10.3389/fpubh.2021.610623/full

Bhattacharya, P., Banerjee, D., & Rao, T.S. S. (2020). The "untold" side of COVID-19: Social stigma and its consequences in India. *Indian Journal of Psychological Medicine, 42(4),* 382-386. https://doi.10.1177/0253717620935578

Bisbey, T. M., Kilcullen, M. P., Thomas, E. J., Ottosen, M. J., Tsao, K., & Salas, E. (2021). Safety culture: An integration of existing models and a framework for understanding its development. *Human Factors*, *63*(1), 88- 110. https://doi.org/10.1177/0018720819868878

Biswas, D., Chatterjee, S., & Sultana, P. (2021). Stigma and fear during COVID-19: Essentializing religion in an Indian context. *Humanities & Social Sciences Communications, 8*, 130. https://doi.org/10.1057/s41599-021-00808-8

Blake, H., Bermingham, R., Johnson, G., & Tabner, A. (2020). Mitigating the psychological impact of COVID-19 on healthcare workers: A digital learning package. *International Journal of Environmental Research and Public Health, 17*(9), 2997. https://doi.org/10.3390/ijerph17092997

Brandford, A. A., & Reed, D. B. (2016). Depression in registered nurses: A state of science. *Workplace health & safety, 64(10)*, 488-511. https://doi.org/10.1177/2165079916653415

Cambridge Dictionary. (n.d.). Remote working. In Cambridge Dictionary.org. Retrieved June 26, 2022, from https://dictionary.cambridge.org/u.s./dictionary/english/remote-working

Carnevale, J. B., & Hatak, I. (2020). Employee adjustment and well-being in the era of COVID-19: Implications for human resource management. *Journal of Business Research*, *116*, 183–187. https://doi.org/10.1016/j.jbusres.2020.05.037

Davidson, J. E., Proudfoot, J., Lee, K., Terterian, G., & Zisook, S. (2020). A longitudinal analysis of nurse suicide in the United States (2005-2016) with recommendation for action. *Worldviews on evidence-based nursing, 17(1)*, 6-15. https://doi.org/10.1111/wvn.12419

Davis, M. A., Cher, B.A., Friese, C. R., & Bynum, J.PW., (2021). Association of US nurse and physician occupation with risk of suicide. *JAMA Psychiatry, 78(6),* 651-658. doi:10.1001/jamapsychiatry.2021.0154

Davis, M., Guille, C. (2021, April 14). Nurses are dying from suicide at higher rates. *Healthy Day News*. Birgham & Women's Hospital. https://www.nursingtimes.net/news/workforce/suicide-risk-higher-among-female-nurses-than-doctors-suggests-study-20-05-2021/

Deane, C., Parker, K., & Gramlich. (2021). A year of US public opinion on the coronavirus pandemic. *Pew Research Center*. https://www.pewresearch.org/2021/03/05/a-year-of-u-s-public-opinion-on-the-coronavirus-pandemic/

Fernandez, R., Lord, H., Halcomb, E., Moxham, L., Middleton, R., Alananzeh, I., & Ellwood, L. (2020). Implications for COVID-19: A systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic. *International Journal of Nursing Studies, 111(2020)*, 103637.

https://doi.org/10.1016/j.ijnurstu.2020.103637

Folkman, S., & Greer, S. (2000). Promoting psychological well-being in the face of

    serious illness: when theory, research and practice inform each other.

    Psychooncology, 9, 11-19. https://doi.org/1002/(sici)1099-

    1611(200001/02)9:1<11:aid-pon424>3.0.co,2-z

Ford, S. (2021, May 20). Suicide risk higher among female nurses than doctors, suggest

    study. *Nursing times*. https://www.nursingtimes.net/news/workforce/suicide-risk-

    higher-among-female-nurses-than-doctors-suggests-study-20-05-2021/

Galanti, T., Guidetti, G., Mazzei, E., Zappala, S., & Toscano, F. (2021). Work from home

    during the COVID-19 outbreak: The impact on employees' remote work

    Productivity, engagement, and stress. *Journal of Occupational and Environmental*

    Medicine, 63(7), e426-e432. https://doi.org/10.1097/JOM.0000000000002236

Gamillo, E. (2021). COVID-19 surpasses 1918 flu to become deadliest in American

    history. *Smithsonian magazine*.

    https://www.smithsonianmag.com/smart-news/the-covid-19-pandemic-is-

    considered-the-deadliest-in-american-history-as-death-toll-surpasses-1918-

    estimates-180978748/

Garfin, D., R., Silver R. C., & Holman, E. A. (2020). The novel coronavirus (COVID-

    2019) outbreak: Amplification of public health consequences by media exposure.

    Health Psychology, 39(5), 355-357.**Error! Hyperlink reference not valid.**

    https://doi.org/10.1037/hea0000875

Gorter, J. (2020, September 11). Impact of the coronavirus on EAPs: Managing the fear

of communicable disease. *Journal of Employee Assistance, 2nd quarter 2020*, 32-

34.

https://archive.hshsl.umaryland.edu/bitstream/handle/10713/12504/Gorter%20Art

icle.pdf?sequence=1&isAllowed=y

Guille, C. (2021). Rate of suicide among women nurses compared with women in the

general population before the COVID-19 global pandemic. *JAMA Psychiatry,*

*78(*6), 597–598. doi:10.1001/jamapsychiatry.2021.0141

Hadi, S. A., Bakker, A. B., & Hausser, J. A. (2021). The role of leisure crafting for

emotional exhaustion in telework during the COVID-19 pandemic. *Anxiety, stress*

& coping, 34(5), 530-544. https://doi:10.1080/10615806.2021.19033447

Hamouche, S. (2021). COVID-19 physical distancing in the workplace and employees'

mental health: Implications and insights for organizational interventions –

narrative review *Psychiatria Danubina*, *33*(2), 202–208.

https://doi.org/10.24869/psyd.2021.202

Hanisch, S. E., Twomey, C. D., Szeto, A. C., Bimer, U. W., Nowak, D., & Sabariego, C.

(2016). The effectiveness of interventions targeting the stigma of mental illness at

the workplace: a systematic review. *BMC psychiatry, 16(1),* 1-11.

https://doi.org/10.1186/s12888s12888-015-0746-4

Hawton, K., & Vislisel, L. (2010). Suicide in nurses*. Suicide & life-threatening behavior,*

29(1), 86-95. https://doi.org/10.111/j.1943-278X.1999.tb00765.x

Healthy People 2020. Health-related quality of life & well-being. Office of Disease

Prevention and Health Promotion. https://www.healthypeople.gov/2020/topics-

objectives/topic/health-related-quality-of-life-well-being

Hidaka, Y., Sasaki, N., Imamura, K., Tsuno, K., Kuroda, R., & Kawakami, N. (2021). Changes in fears and worries related to COVID-19 during the pandemic among current employees in Japan: A 5-month longitudinal study. *Public health, 198*, 69-74. https://doi.org/10.1016/j.puhe.2021.06.017

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., Friedman, M., Gersons, B. P., de Jong, J. T., Layne, C. M., Maguen, S., Neria, Y., Norwood, A. E., Pynoos, R. S., Reissman, D., Ruzek, J. I., Shalev, A. Y., Solomon, Z., Steinberg, A. M., & Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry*, *70*(4), 283–369. https://doi.org/10.1521/psyc.2007.70.4.283

Jadwisiak, M. (2020, May 11). Peer support-A secret weapon in the fight against COVID-19. *Mental health weekly, 30(19)*, 5. https://doi.org/10.1002/mhw.32357

Jahan, I., Ullah, I., Griffiths, M. D., & Mamum, M. A. (2021). COVID-19 suicide and its causative factors among the healthcare professionals: Case study evidence from press reports. *Perspectives in psychiatric care, 2021*,1-5. https://doi.org/10.111/ppc.12739

John, A., Pirkis, J., Gunnell, D., Appleby, L., & Morrissey, J. (2020). Trends in suicide during the COVID-19 pandemic [Editorial]. *BMJ, 2020(371),* m4352. https://doi.org/10.1136/bmj.m4352

Jolley, D., & Patterson, J. L. (2020). Pylons ablaze: Examining the role of 5G COVID-19 conspiracy beliefs and support for violence. *British Journal of Social Psychology,*

59, 628-640. doi:10/1111/bjso.12394

Katz, R. M. (1983). Causes of death among registered nurses. *Journal of Occupational*

  Medicine, 25(10), 760-762. https://doi.org/10.1097/00043764-198310000-00017

Khajuria, A., Tomaszewski, W., Liu, A., Chen, J-h., Mehdian, R., Fleming, S., Vig, S., &

  Crawford, M. J. (2021). Workplace factors associated with mental health of

  healthcare workers during the COVID-19 pandemic: An international cross-

  sectional study. *BMC health services research, 21(262),* 1-11.

  https://doi.org/10.1186/s12913-021-06279-6

Knight, V. (2020). Evidence shows Obama team left a pandemic" game plan" for Trump

  administration. *Kaiser health news*. https://www.pbs.org/newshour/nation/obama-

  tea-left-pandemic-playbook-for-trump-administration-officials-confirm

Lai, J., Ma, S., Wang, Y., Cai, Z. Hu, J., We, N., Wu, J., Du, H., Chen, T., Li, R., Tan,

  H., Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020).

  Factors associated with mental health outcomes among health care workers

  exposed to coronavirus disease 2019. *JAMA Network Open, 3(3),* e203976.

  https://doi.org/10.1001/jamanetworkopen, 2020.3

Linton, M., & Koonmen, J. (2020). Self-care as an ethical obligation for nurses. Nursing

  ethics, 969733020940371. *Nursing ethics, 27(8)*, 1694-1702.

  https://doi.org/10.177/0969733020940931

Luo, M., Guo, L., Yu, M., Jiang, W., & Wang, H. (2020). The psychological and mental

  Impact of coronavirus disease 2019 (COVID-19) on medical staff and general

  Public: A systematic review and meta-analysis. *Psychiatry research, 291*, 113190.

https://doi.org/10.1016/j.psychres.2020.113190

Makwana, N. (2019). Disaster and its impact on mental health: A narrative review.

    Journal of Family Medicine and Primary Care, 8(10), 3090-3095.

    https://doi.org/10.4103/jfmpc.jfmpc_893_19

Manthey, M. (2018). Substance use disorder and the American Nurses Association Code

    of Ethics for Nurses, *Creative Nursing, 24(3),* 163-165.

    https://connect.springerpub.com/content/sgrcn/24/3/163.full.pdf

Matias, T., Dominski, F.H., & Marks, D. F. (2020). Human needs in COVID-19

    isolation. *Journal of Health Psychology, 25(7),* 871-882.

    doi:10.1177/1359105320925149

Matta, S., Arora, V. K., & Chopra, K. K. (2020). Lessons to be learnt from 100 years old

    1918 influenza pandemic vi a vi 2019 corona pandemic with an eye on NTEP.

    The Indian Journal of Tuberculosis, 67(4S), S132-S138.

    https://doi.org/10.1016/j.ijtb.2020.09.032

Maulik, P. K. (2017). Workplaces stress: A neglected aspect of mental health wellbeing.

    The Journal of Medical Research, 146(4), 441-444.

    https://doi.org/10.4103/ijmr.IJMR_1298_17

Maunder, R. G., Leszca, M., Savage, D., Adam, M. A., Peladeau, N., Romano, D., Rose,

    M., & Schulman, R. B. (2008). Applying the lessons of SARS to pandemic

    influenza. An evidence-based approach to mitigating the stress experienced by

    healthcare workers. *Canadian Journal of Public Health, 99(6*), 486-488.

McAlonan, G. M., Lee, A. M., Cheung, V., Cheung, C., Tsang, K. W., Sham, P. C.,

Chua, S. E., & Wong, J. G. (2007). Immediate and sustained psychological impact of an emerging infectious disease outbreak on healthcare workers. *Canadian Journal of Psychiatry. Revue Canadienne de psychiatrie, 52(4),* 241-247. https://doi.org/10.1177/070674370705200406

Merriam-Webster. (n.d.). Telecommute. In Merriam-Webster.com dictionary. Retrieved June 26, 2022, from https://www.merriam-webster.com/dictionary/telecommuting?utm_campaign=sd&utm_medium=serp&utm_source=jsonld

Milot, M. (2019). The impact of a Canadian external employee assistance program on mental health and workplace functioning: Findings from prospective quasi-experimental study. *Journal of Workplace Behavioral Health, 35(3),* 167-191. doi:10.1080/15555240.2019.1609978

Morgan, A.J., Fischer, J.A., Hart, L.M., Kelly, C.M., Kitchener, B.A., Reavley, N.J., Yap, M. B., Cvetkovski, S., & Jorm, A. F. (2019). Does mental health first aid training improve the mental health of aid recipients? The training for parents of teenagers randomized controlled trial. *BMC Psychiatry 19*, 99. https://doi.org/10.1186/s12888-019-2085-8

Mukhtar, S. (2020). The psychological health during coronavirus disease 2019 pandemic outbreak. *International Journal of Social Psychiatry. 66(5),* 512-516. doi:0.1177/0020764020925835

Nguyen, L. H., Drew, D. A., Graham, M. S., Joshi, A. D., Chuan-Guo, M. G., Mehta, R. S. Warner, E. T., Sikavi, D. R., Lo, C. H., Kwon, S., Song, M., Mucci, L. A.,

Stampfer, M. J., Willett, W. C., Eliassen, A. H., Hart, J. E., Chavarro, J. E.,

Rich-Edwards, J. W., Davies, R., Capdevila, J. Lee, K. A., Lochlainn, M. N.,

Varsavsky, T., Sudre, C. H., Cardoso, M. J., Wolf, J., Spector, T.D., Ourselin, S.,

Steves, C. J., Chan, A.T, on behalf of the Coronavirus Pandemic Epidemiology

Consortium (2020). Risk of COVID-19 among front-line health-care workers and

the general community: a prospective cohort study. *The Lancet. Public

health*, *5*(9), e475–e483. https://doi.org/10.1016/S2468-2667(20)30164-X

Oakman, J., Kinsman, N., Stuckey, R., Graham, M., & Weale, V. (2020). A rapid review

of mental and physical health effects of working at home: How do we optimize

Health? *BMC Public Health, 20(1825*), 1-13. https://doi.org/10.1186/s12889-020-
09875-z

Parker, K., Horowitz, J. M., & Minkin, R. (2020). How the coronavirus outbreak has and

hasn't change the way Americans work. Pew research center social and

demographic trends. https://www.pewresearch.org/social-trends/2020/12/09/how-
the-coronavirus-outbreak-has-and-hasn't-changed-the-way-americans-work/

Perez, P. J., Islam, N., & Matiz, L. A. (2020). Community Health Workers and COVID-

19: Addressing Social Determinants of Health in Times of Crisis and Beyond. *The

New England Journal of Medicine, 383(19)*, e108.

https://doi.org/10.1056/NEJMp2022641

Pulido-Martos, M., Cortes-Denia, D., & Lopez-Zafra, E. (2021). Teleworking in times of

COVID-19: Effects on acquisition of personal resources. *Frontiers in psychology,

12,* 685275. https://doi.org/10.3389/fpsyg.2021.685275

Queen, D., & Harding, K. (2020). Societal pandemic burnout: A COVID legacy. *International Wound Journal, 17(4),* 873-874. https://doi.org/10.111/iwj.13441

Rahman, A., & Plummer, V. (2020). COVID-19 related suicide among hospital nurses: Case study evidence from worldwide media reports. *Psychiatric research, 291*, 113272. https://doi.org/10.1016/j.psychres.2020.113272

Reger, M. A., Stanley, I. H., Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019-A perfect storm? *JAMA Psychiatry, 77(1), 1093-1094.* doi:10.1001/jamapsychiatry.2020.1060

Registered Nurses' Association of Ontario. (2008). Health work environment best practice guidelines. Workplace health, safety, and well-being of the nurse. http://www.mtpinnacle.com/pdfs/3089_RNAO_BPG_Health_Safety.pdf

Rothstein, M. A. (2020). Public health and privacy in the pandemic. *American Journal of Public Health, 110(9),* 1374-1375. http://doi.org/10.2105/AJPH.2020.305849

Ryan, B. J., Coppola, D. V., Canyon, M., Brickhouse, M., & Swienton, R. (2020). COVID-19 community stabilization and sustainability framework: An integration of the Maslow hierarchy of needs and social determinants of health. *Social disaster medicine and public health preparedness, 14(5),* 623-629. doi:10.1017/dmp.2020.109

Rutledge, P. E. (2020). Trump, COVID-19, and the War on Expertise. *The American Review of Public Administration*, *50*(6–7), 505 511. https://doi.org/10.1177/0275074020941683

Salari, N., Khazaie, H., Hosseinian-Far, A., Khaledi-Paveh, B., Kazeminia, M.,

Mohammadi, M., Shohaimi, S., Daneshkhah, A., & Eskandari, S. (2020). The

 prevalence of stress, anxiety and depression within frontline workers caring for

 COVID-19 patients: a systematic review and met-regression. *Globalization and*

 health, 16(57). https://doi.org/10.1186/s12992-020-00589-w

Selye, H. (1946). The general adaptation syndrome and the diseases of adaptation. The

 Journal of Clinical Endocrinology and Metabolism, 6, 117-230.

 https://doi.org/10.1210/jcem-6-2-117

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources of

 anxiety among healthcare professionals during the COVID-19 pandemic. J*AMA,*

 323(21), 2133-2134. doi:10.1001/jama.2020.5893

Shao, R., Shim, A., & Zhang, D. (2021a). Social media and emotional burnout regulation

 during the COVID-19 pandemic: Multilevel approach. *Journal of Medical*

 Internet Research, 23(3), e27015. https://doi.org/10.2196/27015

Shao, Y., Fang, Y., Wang, M., Chang, C.D., & Wang, L. (2021b). Making daily decisions

 to work from home or to work in the office: The impacts of daily work-and

 COVID-related stressors on next-day work location. *The Journal of Applied*

 Psychology, 106(6), 825-838. https://doi.org/10.1037/apa1000929

Shaw, D. (2020). Invisible enemies: Coronavirus and other hidden threats. *Journal of*

 Bioethical Inquiry, 17(4), 531-534. doi:10.1007/s11673-020-10015-w

Shingler-Nace, A. (2020). COVID-19: When leadership calls. *Nurse leader, 18(3),* 202-

 203. https://doi.org/10.1016/j.mnl.2020.03.017

Shinners, J. S., & Africa, L. A. (2021). Rapid Validation of Clinical Competencies in a

Time of Crisis. *Nurse leader*, *19*(2), 139–144.

https://doi.org/10.1016/j.mnl.2020.06.012

Siddiqui, S., & Singh, T. (2016). Social media its impact with positive and negative

aspects. *International Journal of Computer Applications Technology and

Research, 5(2),* 71-75. ISSN:2319-8656

Sikali, K., (2020). The dangers of social distancing: How COVID-19 can reshape our

social experience. *Journal of Community Psychology, 48(8),* 2435-2438.

https://doi.org/10.1002/jcop.22430

Simon, J., Helter, T.M., White, R.G., Van der Boor, C. & Laszewska, A. (2021). Impact

of the COVID-19 lockdown and relevant vulnerabilities on capacity well-being,

mental health, and social support: An Austrian survey study. *BMC Public Health,

21*, 314. https://doi.org/10.1186/s12889-021-10351-5

Smith, L. E., Duffy, B., Moxham-Hall, V., Strang, L., Wessely, S., & Rubin, G. J. (2021).

Anger and confrontation during the COVID-19 pandemic: A national cross-

sectional survey in the UK. *The Royal Society of Medicine, 114(2)*, 77-90.

doi:10.1177/0141076820962068

Spencer, J. (2020). Why we are tracking every US health worker who dies from

coronavirus. The Guardian.com. https://www.theguardian.com/us-

news/2020/apr/15/why-were-tracking-every-us-health-worker-who-dies-from-

coronavirus -coronavirus

Suh, J., Horvitz, E., White, R. W., & Althoff, T. (2021). Population-scale study of human

needs during the COVID-19 pandemic: Analysis and implications. WSDM 21:

Proceedings of the 14th ACM International conference on web search and data mining, 4-12. https://doi.org/10.1145/3437963.3441788

Tan, W., Chew, N., Lee, G. Jing, M., Goh, Y., Yeo, L., Zhang, K., Chin, H. K., Ahmad, A., Khan, F. A., Shanmugam, G. N., Chan, B., Sunny, S., Chandra, B., Ong, J., Paliwal, P. R., Wong, L. Sagayanathan, R., Chen, J. T., Ng, A., … Sharma, V. K. (2020). Psychological impact of the COVID-19 pandemic on health care workers in Singapore. *Annals of internal medicine, 173(4),* 317-320. https://doi.org/10.7326/M20-1083

Taylor, S., Landry, C. A., Paluszek, M. M., Fergus, T. A., McKay, D., & Asmundson, G. J. (2020). COVID stress syndrome: Concept, structure, and correlates. *Depression and anxiety, 37(8),* 706-714. https://doi.org/10.1002/da.23071

Teskin, G. Uluyol, O. B., Onur, O. S., Teskin, M. G., & Odemir, H. M. (2020). Stigma-related factors and their effects on healthcare workers during COVID-19 in Turkey. *The medical bulletin of SISLI ETFAL Hospital, 54(3)*, 281-290. doi.10.14744/SEMB.2020.02800

Toniolo-Barrios, M., & Pitt., L. (2021). Mindfulness and the challenges of working from home in times of crisis. *Business horizons, 64(2),* 189-197. https://doi.org/10/1016/j.bushor.2020.09.004

Upshur, R. (2003). The ethics of quarantine. *AMA Journal of Ethics, 5(11),* 393-395. doi:10.1001/virtualmentor, 2003.5.11.msoc1-0311

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support.

International Journal of Mental Health Nursing, 29, 549-552

doi:10.1111/inm.12735

Vizheh, M., Qorbani, M., Arzaghi, S. M., Muhidin, S., Javanmard, Z., & Esmaeili, M. (2020). The mental health of healthcare workers in the COVID-19 pandemic: A systematic review. *Journal of diabetes and metabolic disorders*, *19*, 1967-1968. https://doi.org/10.1007/s40200-020-00643-9

Wang, B., Liu, Y., Qian, J. M., & Parker, S.K. (2020a). Achieving effective remote working during COVID-19 pandemic: A work design perspective. *Applied psychology: An International Review, 70(1),* 16-59 doi:10.1111/apps.12290

Wang, L., Norman, I., Xiao, T., Li, Y., & Leamy, M. (2021b). Psychological first aid Training: A scoping review of its application, outcomes, and implementation. *International Journal of Environmental Research and Public Health*, *18*(9), 4594. https://doi.org/10.3390/ijerph18094594

Watson, P. (2021a). *The COVID-19 Protection to Ensure Resilient Health Care Workers SFA Implementation Guide for Site Champions.*

Watson, P. J. (2021b). Application of the Five Elements Framework to the COVID-19 pandemic. *Psychiatry, 84(4)*, 415-429. doi:10.1080/00332747.2021.2005446

Watson, P., & Westphal, R. J. (2020). Stress First Aid for Health Care Workers. National Center for PTSD. Available on: www.ptsd.va.gov.

Worldometer. (2020). Worldometer COVID-19 Coronavirus pandemic. https://www.worldometers.info

Xiao, Y., Becerik-Gerber, B., Lucas, G., & Roll, S. C. (2021). Impacts of working from

home during COVID-19 pandemic on physical and mental well-being of office workstation users. *Journal of Occupational and Environmental Medicine, 63(3),* 181-190. https://doi.org/10.1097/JOM.0000000000002097

Yi, Y., Lagniton, P., Ye, S., Li, E., & Xu, R. H. (2020). COVID-19: What has been learned and to be learned about the novel coronavirus disease. *International Journal of Biological Sciences*, *16*(10), 1753–1766. https://doi.org/10.7150/ijbs.45134

Yildirim, T.T., Atas, O., Yidirm, K., & Balibey, H. (2020). Psychological status of healthcare workers during the COVID-19 pandemic. *Journal of College of Physicians and Surgeons—Pakistan: JCPSP, 30(6),* 26-31. https://doi.org/10.29271/jcpsp.2020.Supp1.S26

Appendix A: Literature Review Matrix

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s) Hypotheses	Methodology	Analysis & Results	Conclusions	Implications for Future research	Implications For practice
Albott et al., 2020	Battle buddies	Individuals who are involved in resilience efforts are less likely to develop traumatic stress or burnout.	Multi-level approach. Stress inoculation methods, peer support. Battle Buddy and a designated mental health provider Institutional data collection.	Psychological Resilience Intervention Can be used as a tool for self-care.	Level 1 Battle Buddy can be a stand-alone intervention in the absence of a dedicated mental health component and tailored for the individuals at no cost.	Educational and training in peer support.	Strategies to protect the psychological impact on healthcare workers. Promote resilience.
Blake, et al., 2020	Development of a digital learning E-learning	Immediate need to address the psychological impact on healthcare workers.	Agile is a three-step process methodology: Three-step process (1) public involvement activities; stakeholders (2) content/technical development with iterative peer review; (3) delivery and evaluation.	Within the first week, the digital package had been reviewed 17,633 times.	The evaluation showed success in usability, utility, and cost-effectiveness. Well received by stakeholders as an education and training intervention for psychological stressors.	Dissemination to validate and tailor to its population.	Free and adaptable. Focuses on individual and organizational work-related stress to develop and promote resilience.
Davidson et al., 2020	Nurse suicide in America	Pre-pandemic there was an alarming increase in nurse suicides.	Retrospective cohort longitudinal study to examine the incidence of suicide and its relationship to social and mental risk factors.	1,824 nurses and 152,495 non-nurse suicides	Female nurse suicides were higher than male nurses. Nurses are 1.4% higher than the general population. Female nurse suicide is twice the number of the general population. Method of choice Benzodiazepines and opioids.	More research is needed on the psychological factors that contribute to nursing suicides.	Strategies to quickly identify impaired nurses with substance abuse and provide available resources and, health promotion.
Davis, 2021	Occupational risk for suicide	Is the risk of suicide among US nurses and physicians greater than that in the general population?	Cohort Study 2007-2018	Measured incidence and characteristics n suicides. 2,374 nurses, 857 doctors, 156,141.30 years or less.	Female nurses 17.1/100,000 2017-2018; doctors 10.1%, 8.6% general population. Nurses were higher and 2 times greater than the general population.	More research studies nurse suicide.	Suicide prevention programs for nurses
Galanti, et al., 2021	Jobs Demand-Resources Model (2001)	Would the findings from this study support the evidence already reported?	A cross-sectional online questionnaire study	209 participants working in the home.	Flexibility and self-discipline were not affected. Navigating school schedules, family-work balance, social isolation,	Examine psychological stressors of employees working.	Change in practice allows for permanent telework. Strategies for family-work balance.

Guille, 2021	Suicide in female nurses	Work-related stress and mental compromise.	Three-tier integrative approach method to address work-related stress and mental health compromise.	The first tier develops primary prevention. Second-tier strategies to identify nurses at risk. The third tier creates gender-specific target factors.	Female nurses composed 88% of the nurse workforce and unique work-related stressors that lead to mental compromise. Females are twice as likely not to commit suicide compared to the general population.	Nurse suicide and s, work-related stressors lead to mental compromise.	Health promotion and prevention programs are gender-specific for nurses. Educational awareness and training.
Hamouche, 2020	Impact of psychological distress and depression	Moderating factors mitigate or aggravate the impact of COVID-19.	Literature review of multiple databases that searched for historical research studies due to the paucity of research in July 2020.	Negative impact. Stressors-safety, threat, risk of contracting, confinement, too much information, fear of unknown, quarantine, stigma and social inclusion, financial loss, and job security.	19 negative Stressors, such as safety, threat, and risk of spreading to others, fear of the unknown, quarantine and confinement, stigma,	Individual and organizational factors from a social perspective.	Prevention of stigma, communication, transparency, training. Plan for return-to- that will address pandemic and quarantine fatigue.
Khajuria, et al., 2021	Work-related stressors and mental health	Healthcare workers were under tremendous pressure.	A first Inter-national cross-sectional study in 41 countries. Chinese and South Asian healthcare professionals	2527 healthcare professionals. China (n=1213; 48%), the United Kingdom (n=891; 35.3%), and the United States (n=252; 10%) composed 93.3% of the participants.	Supported previous studies. The majority (80%) of the participants were female. 50% of the participants were young, 26 to 40 years.	Strategies to assist young nurses.	Mentoring for young nurses. Employee support programs
Maunder et al, 2008	Lessons from the past	Healthcare workers with years of experience are more likely	Folkman and Geer's framework in an evidence-based approach.	Historical data lessons from the past can be applied to build resilience.	Psychological First Aid (PFA) evidence-based program to address	More is needed in peer support in addressing psychological stress among	Foster peer support and , organizational support measures to promote resilience.

		than not to experience increased mental health stressors.		Insufficient training can cost lives.	trauma and promote coping mechanisms.	healthcare workers.	Education and training.
Mukhtar, 2020	Psychological impact of COVID on society, communities	Factors influenced by current events.	Literature review	Historical data pandemics,, epidemics and the how to uncertainty of the unknown	Uncertainty of the unknown widespread has a negative impact on psychological well-being.	Recommended more studies in phobias and negative consequences, of coronophobia, stigma, xenophobia, nosophobia	Ensure obtaining and giving accurate information.
Nguyen, et al., 2020	COVID Symptoms	Limited data. Study nurses. PPE, and general population	Observational prospective cohort, self-reported data COVID symptom mobile app March 24, 2020, to April 23, 2020.	Cox proportional hazards modeling for multivariate-adjusted hazards in primary outcomes- a positive COVID-19 test.	The COVID System Study app. 2,035,395 individuals, 99,795 nurses in the sample. 5,545 incident reports of a positive COVID-19 test over 34,435,272 person-days. Frontline Increased risk for positive test. PPE, work environment, and ethnic background differences. Negative views not only create psychological stressor that can lead to violence again ethnic groups.	Research using the COVID Symptoms smartphone app.	Ensure adequate supplies of protective equipment for front line workers. Strategies for safety, specifically, African American, Asian, and minority ethnic populations
Oakman, et al., 2020	Mental and physical impact of mandatory working from home.	The inability to separate physical and operational boundaries can negatively impact the physical and	A rapid review in mental and physical health effects on teleworkers to develop recommendations for employers and employees.	Qualitative data narrative synthesis to identify influence on employees physical and mental well-being. Studies were placed into widespread	Out of 1,557 papers, 21 were chosen. Two addition studies were added to make 23 after reference list review. The PRISMA diagram revealed the	Longitudinal research to examine employees and organization while teleworking that will potentially help to develop guidelines to reduce the	Strategies to address teleworkers must be based on the best available evidence to promote the best health outcome. Key themes organizational support, co-worker

		mental well-being of the employee.			health outcomes followed by a separate gender analysis.	process. Ten countries were represented. There were 19 quantitively and 3 qualitative studies. Three studies were related to physical and work from home which may have been linked to review of literature. It was reported mental health outcomes were in most of the studies.	negative impact and promote health	support, technical support, boundary management support, gender inequalities.
Rahman & Plummer, 2020	Nurse suicide	Lessons learned from the past in developing and implementing evidence-based disaster management programs.		Retrospective analysis to identify COVID-19 related factors among six critical care nurses 20-49 years of age. Criteria was employed in a hospital setting that committed suicide, worked with most severe patients, exposed, contracted, or quarantined.	Two of the six nurse volunteered in the early stages of COVID-19. Four had worked in the facilities prior to COVID-19.	Lack of disaster management and critical life-saving equipment, shortages, long hours with very ill patients, fear of contracting and transmitting to family members. Nursing leaders are in the optimal area to bring changes in practice that support mental well-being.	New nursing models to address emotional distress.	Interprofessional collaborative teams to strategize new nursing models and work practices that address emotional distress.
Shanafelt, Ripp, Trockel, 2020	Understanding and addressing sources of anxiety	Maintaining a healthy workforce is essential.		First week of COVID, 69 total and eight focus groups comprised of physicians, nurses, advanced practice	Three major concerns: what healthcare professionals were most concerned about, what	Eight sources of anxiety were: PPE, exposure and transmitting to family, access to testing, uncertainty of organizational support,	Mental well-being among healthcare professionals and strategies to address the eight causes of anxiety identified in this study.	Develop targeted strategies based on the concerns that cause anxiety.

			healthcare professionals, residents, and fellows.	messaging, and behaviors healthcare professionals needed from their leaders, and rapid access to testing.	access to childcare during long hours and school closures, support for personal and family medical care if healthcare professional is sent to other areas, competencies, lack of access to accurate information. Some may not be impacted by stressors, but an unhealthy workforce can lead to a breakdown in quality of care and the organization itself. The eight causes of anxiety were grouped into categories for leadership; hear me, protect me, prepare me, support me, and care for me.		
Shao, Shim, & Zhang, 2021	Social media and emotional burnout	With the lockdowns, social media increased for information some at times was incorrect.	Holistic and multilevel approach online panel sampled 538 Chinese internet users. Surveyed data for 12 days from February 7-18, 2020, two weeks after Hubei Province went under quarantine.	Structural equation modeling	Findings were like evidence previously reported. Individuals share one another's negative posts. Interpersonal and intrapersonal levels serve as a buffer for burnout. In contrast interpersonal and interpersonal and hyper-personal (social media) disclosing and retweeting	Explore benefits of intrapersonal and interpersonal emotional regulations.	The need to provide accurate information caused by infodemics.

				negative emotions-negative related.			
Shao, et al., 2021	Socio ecological perspective work at home	Factors that drive choice to work in the home instead of office setting.	Collected data over five days from 127 Chinese workers in IT were allowed to decide their workday. Work-family boundary stressors and work coordinator stressors.	Family stressors more likely than not was a driving force in the return to the office setting. When work coordinator stressors were greater the person more likely than not to work from home. Work-related stress technology stressors influenced work from home.	Implications for driving factors that determine whether to return to the office setting or work from home.	More research in work-related, technology-related, family-related stressors impact.	Offer more flexibility in work in home settings verses in-person. Self-care and care for other strategies to balance stressors in the home and work.
Taylor, et al., 2020	COVID-19 Stress Syndrome	There were more people that feared the disease than had the disease.	6,854 American and Canadian adults Self-report survey current mental health and covid-related experiences, distress, and coping	Network analysis worry about dangers of COVID-19. Latent class analysis syndrome is quasi-dimensional. 16 % preexisting psychological issues and with obsessive related avoidance, panic buying, and coping difficulties during self-isolation.	Study provided new information. Danger is the central of the covid syndrome. There are five classes of different syndromes ranging in severity.	Future research of whether the covid stress syndrome will dissipate after the pandemic or whether it becomes long-term.	Strategies to address fear of encountering infectious people, worry, xenophobic fears, traumatic stress.
Wang, et al., 2020	Remote working	Psychological challenges and risk from working from home.	Mixed method survey and interview	552 Chinese teleworkers acute	Four challenges procrastination, inadequate	Impact of teleworking long-term.	Review remote workers agreements.

				phase of pandemic	communication, work interference, and loneliness. Four virtual work characteristics -social support, job autonomy, monitoring, workload. Key factor was self-discipline. Working from home was linked to work performance and well-being. Job autonomy related to loneliness. Social support less of a challenge.		Need to strength social support.
Xiao, et al. 2021	Social, behavioral, and physical factors on well-being	Measured lifestyle and home environment, occupational environment, home office environment, and physical and mental well-being.	Anonymous questionnaire from April 24 to June 11, 2020. Linear regression, multinominal logistic regression, and chi-square tests	Descriptive statistics 998 valid responses. Revealed stressors that affect individuals working from home and provided a framework for how to support the physical and mental well-being.	The level of physical activity impacted mental well-being. Lifestyle factors were also impactful, as well as distractions, support. New health issues also emerge with decrease in physical and mental well-being. Female workers making less than 100 K suffered from one or more mental issues than their counterparts. Women also faced more responsibilities while working from home.	How to support employees working in the. home.	Work boundaries, health impact, ergonomics, nutrition. How to support female workers.

Appendix B: Introductory Letter to Colleagues

Dear Colleague,

My name is Medina Hudson-Odoi, and I am a Doctoral Candidate at Walden University School of Nursing. Part of the criteria for graduation is implementing a staff education project. In addition, the Doctor of Nursing Practice Capstone is an independent scholarly research study that demonstrates critical thinking and academic writing, competence in research and research design, and contributes directly or indirectly to healthcare (Walden University, 2020).

The title of the project is *The Psychological Impact of COVID-19*. The purpose is intended to close a gap of knowledge among healthcare professionals in supporting the unique psychological stressors that emerge during COVID-19 while working in home and office work settings. Additionally, the literature supports a gap in organizational support to address emotional distress among healthcare professionals during and after a pandemic, epidemic, natural, or manufactured disaster. In disaster management, organizations and Nursing Leaders were tasked with a unique situation where the most sophisticated organization can be vulnerable and ill-equipped to support their employees.

The approximate time for this project is 60 minutes. For the research study, I ask you to complete the demographic survey, posttest, and evaluation survey. Please do not include any sensitive data on any of the documents. I will email a hyperlink to the surveys within the meeting invite.

Timeline to Complete the Staff Education Project

- Demographic Survey   3-4 minutes
- Stress First Aid Training   45-minutes

- Posttest   3-minutes
- Evaluation   3-minutes

The analysis of the collection of data will aid in making improvements to strengthen the project and potentially implement Stress First Aid at our agency. Please allow me to thank you in advance for taking the time out of your busy schedule to participate in this project.

Respectfully,
Medina Hudson-Odoi

Appendix C: Demographic Characteristics Survey

Please do not add sensitive data. The survey is anonymous and will take approximately four minutes to complete.

1. What is your gender?
a. Female
b. Male
c. LGBTQ
d. I prefer not to say
e. Other (please specify)

2. How satisfied are you with your current work-from-home arrangement?
a. Very satisfied
b. Somewhat satisfied
c. Neither satisfied nor dissatisfied
d. Somewhat dissatisfied
e. Very dissatisfied

3. What is your age?
a. 18-34 years
b. 35-49 years
c. 50 years and older

4. What is your marital status?
a. Single
b. Married
c. Widowed
d. Separated
e. Divorced
f. Other (please specify)

5. What is your ethnic background?
a. Caucasian
b. African American
c. Native American
d. Pacific Islander
e. Asian
f. Hispanic
g. Latino
h. Other (please specify)

6. Do you have any children?
a. Yes

b. No

7. What is the highest educational level you have achieved?
a. Associate Degree
b. Bachelor's degree
c. Master's degree
d. Post-Master's Certificate
e. Doctorate
f. Other (please specify)

8. How would you best describe your profession?
a. Registered Nurse
b. Advanced Practice Registered Nurse
c. Nurse Consultant
d. Healthcare System Specialist
e. Physician Assistant
f. Social Worker
g. Other (please specify)

9. How many years of experience do you have in your occupation?
a. Less than five years
b. 6-10
c. 11-20
d. Over 20 years

10. How many years have you worked for your current employer?
a. Five years or less
b. 6-10 years
c. 10-20 years
d. Over 20 years

11. If given the opportunity, would you continue to work at home?
a. Yes
b. No

12. For this study, what were the THREE biggest challenges you faced while working from home?
a. My physical workspace
b. Too many distractions at home
c. Internet connectivity
d. Childcare
e. Social isolation
f. Prolonged lockdowns
g. Social engagement

h. I'm sick or helping others who are sick
i. Keeping a regular schedule
j. Navigating homeschooling schedules
k. Uncertainty about the future
l. Pandemic fatigue
m. Loss and grief
n. Worship services
o. Other (please specify)
p. None of the above

13. With the massive closures and prolonged locked downs, how worried were you about the psychological impact of the coronavirus among healthcare professionals?
a. Extremely worried
b. Very worried
c. Somewhat worried
d. Not as worried
e. Not at all worried
f. Other (please specify)

14. During the past four weeks, how supported did you feel when you wanted or needed help from others? For example, if you felt lonely and wanted to talk to someone or got sick.
a. Extremely supported
b. Very supported
c. Somewhat supported
d. Not so supported
e. Not at all supported

15. In comparison to teleworking from your home office versus in-person, how would you describe your feelings/concerns/anxieties/benefits of returning to an in-person presence in the office?
a. Optimistic
b. Pessimistic
c. Frustrated in having to return
d. Other (please specify)

16. Which of the following would make you feel more comfortable returning to work in the office?
a. Employee COVID check-in mobile apps
b. Checking temperature at all entrances
c. Requiring face masking in the office to protect vulnerable employees with chronic health   conditions
d. Social and physical distancing
e. Hand sanitizer and facial mask stations

f. Limiting the number of employees in the office at one time
g. Adequate ventilation and air purifiers
h. Availability of antibody testing
i. Nothing would make me feel more comfortable
j. Other (please specify)

17. Which of the following would upset you if required when returning to work in the office? (Select all that apply.)
a. Antibody testing
b. Closing any communal spaces (e.g., gym, game room)
c. Installing a contact tracing app
d. Clean desk policy
e. Partitions in between desks
f. Nightly deep cleans/sanitation
g. Boxed lunches instead of buffet-style lunches
h. Temperature checks before entering the building
i. Staggering hours/shifts
j. Staggering lunchtimes
k. Wearing masks in the office
l. Limiting the number of employees in the building
m. Getting a vaccine.
n. Restricts visitors to the building
o. Something else (please specify)

18. How comfortable do you feel voicing your concerns to your supervisor?
a. Extremely comfortable
b. Very comfortable
c. Somewhat comfortable
d. Not so comfortable
e. Not at all comfortable

19. Would you recommend disaster management training for all agency employees?
a. Yes
b. No
c. Other (please specify)

20. How comfortable do you feel sharing new ideas and suggestions with leadership at work?
a. Extremely comfortable
b. Very comfortable
c. Somewhat comfortable
d. Not so comfortable
e. Not at all comfortable

Appendix D: Stress First Aid Knowledge Check

Knowledge Check Posttest

Please do not add sensitive data to this survey. The survey is all multiple choice and will take approximately three minutes to complete and submit.

1. Stress First Aid is a self-care, leadership, and peer support model developed for individuals working in high-risk environments. What are the essentials of Stress First Aid?

a. Caring, Mindful, and Non-judgmental
b. Recognize, Act, Know
c. Check, Coordinate, Calm
d. Trust, Tone, Timing

2. Why should an organization implement Stress First Aid?

a. Close a gap in how to address psychological stressors among healthcare professionals.
b. Promotes early actions for stress reactions.
c. It's a bridge over unchartered waters.
d. Highlights the importance of coworker support.

3. Where does Stress First Aid Fit in the Stress Continuum?

a. Green Zone
b. Yellow Zone
c. Orange Zone
d. Red Zone

4. What operational continuum zone is caused by life experiences, loss, moral injury, and wear and tear?

a. Green
b. Yellow
c. Orange
d. Red

5. Hobofoll et al., 2007 reported individuals tend to recover from stress actions better if they sense one or more of the essential elements linked to the five factors in recovery from stress and adversity. From the list below, please select the five factors of recovery.

a. Cover, Calm, Connectedness, Competence, Confidence
b. Safety, Calming, Connectedness, Collective-efficacy, Hope

c. Faith, Open-mindedness, Confidence, Self-efficacy, Connectedness
d. Safety, Trust, Self-efficacy, Sense of social connectedness, Hope

6. Choose the evidence-based mode of communication you may use in approaching a coworker experiencing a stress reaction?

a. SOS Scale of Communication
b. Face-to-Face Communication
c. OSCAR Method of Communication
d. Stress Continuum Model

7. The Stress First Aid Model includes seven evidenced-based essential stress responses, but there are two stress responses that move up and down the spectrum on a continuous cycle to aid in identifying early warning signs of stress. What are the two continuous essential stress responses?

a. Check and Calm
b. Check and Competence
c. Check and Confidence
d. Check and Coordinate

8. If you encounter individual(s) that are angry, the Calm stress response action recommends applying the least intrusive non-verbal and/or verbal calming action to:

a. Distract the individual(s) by suggesting they take a break.
b. Distance the angry individual(s) from the situation and keep them engaged.
c. Defuse by suggesting they look at the situation from a different perspective.
d. Deter and get assistance if you feel uncomfortable or threatened.

9. Why is coworker support so important?

a. Healthcare professionals often place others before self.
b. High functioning healthcare professionals are at-risk for stress injuries.
c. Some healthcare professionals will not seek mental health services due to stigma.
d. A bridge to higher levels of care.
e. There is evidence that early treatment for significant stress is effective.

10. Stress First Aid has many characteristics that are different from other employee support models like Critical Incident Stress Debriefing (CISD), such as:

a. Stress First Aid is a "one size fits all" employee support model.
b. Provides a common language to talk about stress reactions, via SCM reducing stigma.
c. It specifically targets work-related stress.
d. Owned by the community and operated by its leaders and members

Appendix E: Stress First Aid Core Evaluation

Please do not enter any sensitive data to this survey. Rate the extent to which you agree or disagree with the following statements. The evaluation will take approximately two minutes to complete.

1-Strongly disagree, 2 Disagree, 3 Neither agree or disagree, 4 Agree, and 5 Strongly agree

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1. Appraise the foundation of Stress First Aid.

a. Strongly, disagree
b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly, agree

2. Delineate the Stress Continuum Model
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

3. Described the Stress First Aid Essential Seven Cs of Stress Responses.

a. Strongly, disagree
b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly, agree

4. Appraise the significance of coworker support.

a. Strongly Disagree
b. Somewhat Disagree
c. Neither Agree nor Disagree
d. Somewhat Agree
e. Strongly Agree

5. I was able to relate each of the learning objectives to the learning I achieved.

a. Strongly, disagree

b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly, agree

6. I found the course materials easy to navigate.

a. Strongly, disagree
b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly, agree

7. I will be able to immediately apply what I learned.
a. Strongly, disagree
b. Disagree
c. Neither agree nor disagree
d. Agree
e. Strongly, agree

8. My learning was enhanced by the knowledge of the facilitator.
a. Strongly Disagree
b. Somewhat Disagree
c. Neither Agree nor Disagree
d. Somewhat Agree
e. Strongly Agree
f. Other (please specify)

9. How likely are you to use some or all the knowledge and skills taught in this training
in your personal life?

a. Very unlikely
b. Unlikely
c. Neither likely nor likely
d. Likely
e. Very likely

10. I was satisfied with the course overall.

a. Very dissatisfied
b. Dissatisfied
c. Neither satisfied nor dissatisfied
d. Satisfied
e. Very satisfied

Appendix F: Components of the Stress First Aid Model

SFA Components	Description	Application
Stress Continuum Model	SCM is the core of the SFA model. SCM is a visual aid of four colors that represents the zones of stress that lie on a spectrum ranging in severity from healthy to ill. SCM is described in a common language that can easily identify the zone of stress, its characteristics, and stress reaction which helps also to reduce stigma. The Green or Ready is ultimate well-being. The individual manages daily stress, or it resolves spontaneously. The yellow or Reacting zone of stress may display mild or transient signs or symptoms and may be noticeable and the individual manages with self-care or coworker support. The orange or Injured zone of stress on the spectrum indicates an individual possesses one or more of the four stress injuries with persistent and more severe signs and symptoms. If the spectrum advances to the Red or Ill zone immediate action is needed because the symptoms worsened and there is a loss of functioning and mental health services are needed. Therefore, movement on the spectrum depends on individual experiences, the	Green zone stress reactions may include self-care strategies, i.e., yoga, mindfulness, adequate rest, nutrition, and physical activity. The yellow zone of stress offer or accept support, rests, and continues to monitor for resolution. To identify early recognition and early warning signs of stress injury an individual monitors for "red flags" in self or coworkers. Orange zone of stress indicators, i.e., recent events, emotional distress, change in functioning and apply the 7 Cs of SFA.

	zone of stress, stress reaction, and stress response.	
Stress Injuries	Stress injuries may emerge from four potential causes: trauma, loss, inner conflict, or wear and tear, which can move an individual from the yellow zone of stress to the orange or red zones. (1) Trauma or traumatic injury is an unprecedented experience or exposure to death, an injury, horrific or gruesome event. (2) Loss or grief injury because of the loss of people, pets, materialistic, or oneself. (3) Inner conflict or moral injury from human behavior or witnessing the suffering that goes against your moral compass or values. (4) Wear and tear or a fatigue injury occur when there is an accumulation of chronic stress with no means of recovery.	Apply the SCM color-coded visual aid to identify the zone of stress, cause, characteristics, and the stress response that corresponds. The goal is to avert a worsening of symptoms.
SFA 7 Cs	The SFA 7 C's, Check, Coordinate, Cover, Calm, Connect, Competence, and Confidence, derived from the five factors of recovery from adversity and stress are applied to avert a worsening of symptoms.	Check and Coordinate are continuous in the process and applied to each of the five essential stress responses. Cover action promotes safety by removing self or coworker away from the stressors as quickly as possible. Calm action is intended to deescalate the stressor through remaining calm and relaxation techniques. Connect with others, family, coworkers, and social connect. Competence action restores self-efficacy and self-collectiveness. Confidence action is to restore self-esteem, faith, and hope.

Source: Watson, Westphal, & National Center for PTSD (2020)

Appendix G: Stress First Aid Educational Program Curriculum

Learning Objectives	Goals	Key Teaching Points	Measurable Outcomes	Met/Not Met
Appraise the foundation of Stress First Aid	*Participants will understand the basic concepts of how SFA's five evidence-based elements are linked to better functioning after stress and adversity across several settings, including Safety (Cover), Calming, Connectedness, Self-efficacy (Competence), and Hope (Confidence), and its importance to SFA.*	PP #13, #19, #23, #24 Instructors Manual	Question # 5 Question #1	Kirkpatrick's Levels of Learning. Level 1 Level 2 p
	Participants will understand the three essentials of SFA (Recognize, Act, and Know at least two trusted resources outside of EAPs) and when SFA is needed.			
Delineate the Stress Continuum Model	The participant will be able to identify early warning signs of stress in self and others along a spectrum of the SCM (visual aid) Ready (Green), Reacting (Yellow), Injured (orange), Ill (Red). and to help reduce the likelihood that stress outcomes develop into more severe or long-term problems.	PP #13, #14, #23, #24	Question #3 Question #4 Question #4	

	Participants will be able to associate the Four Types of Stress (Life Threat, Loss or Grief, Inner Conflict, Wear & Tear)		Question #4
			Question #8
	The participant will recognize "red flags" that may indicate self, or a coworker is moving toward the Orang Zone.		
Describe the SFA Seven C's and	Be able to apply the Four D's (Distract, Defuse, Distance, and Deter to an angry coworker Participants will understand the five evidence-based elements Cover (Safety), Calming, Connectedness, Competence (Self-Efficacy), and Confidence (Hope), and how they align with recovery from stress and diversity.	PP Slide #22-#68	Question #7
			Question #5
			Question #6
	Participants will understand concepts for Check and Coordinate.		
	The role and five steps of OSCAR (Observe, State Observations, Clarify Role, Ask Why, Respond) communication and why it is useful during Check.		

Appraise the significance of coworker support.	Foster peer support. Fully implement SFA. Coordinate-peer support teams, local counselors, Chaplains, and others who may have experienced a similar situation.	PP # 9, #13, #14, #16, #50	Question #2

Source: Watson, Westphal, & National Center for PTSD (2020)