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Nursing Practice Meets Theory

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Executive Summary

These are challenging times for nurse leaders. Over the last decade, debates on healthcare reform have focused on the cost of care in the United States. This discussion has placed increasing pressure on nurse leaders to operate organizations that are more efficient, while improving quality and patient outcomes.

The practice of commanding and directive leadership has never been effective long term. Nurses want leaders to make sense of a situation and explain the *why*. With the growing trend toward hospital reimbursement for performance measures that are nurse-driven and informed consumers with higher expectations than ever before, it is vital that nurse leaders help nurses reconnect to their purpose in order to obtain these goals.

A large, integrated, not-for-profit healthcare system in the Northern California (NCAL) region witnessed a decrease in their Hospital Compare Assessment of Healthcare Providers and Systems (HCAHPS) summary star rating. Despite the significant financial investments to improve patient satisfaction, this healthcare system was not seeing the benefits.

The intent of this project was to actualize Jean Watson's human caring theory, support care experience best practices that promote patient satisfaction, and transform cultural norms that move the caring theory from a conceptual level to an operational level in a small urban hospital. "It is hoped that some level of this work will help us all, in the caring-healing profession, to remember who we are and why we have come here to do this work in the world" (Watson, 2008, p. 41). Outcomes were an improvement in summary star of 2.8 to 3.1 within three months of implementation of this project within the identified facility and sustained for 15 months, despite significant turnover in nursing leadership. Next steps will be to spread this project region-wide to continue to improve the organizational overall summary star rating.

Section II. Introduction

Problem Description

A large, integrated, not-for-profit healthcare system in the Northern California (NCAL) region witnessed a decrease in their Hospital Compare Assessment of Healthcare Providers and Systems (HCAHPS) summary star rating. The HCAHPS survey contains patient perspectives on care and patient rating items that encompass eight key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care. These questions encompass critical aspects of the patient's hospital experience and are publicly reported (Centers for Medicare & Medicaid Services [CMS], 2017). The NCAL region was averaging a summary star of 3.0 as of June 2018, a 0.2 decrease compared to baseline of 3.2 the end of September 2017 (Mingming, 2018). Despite significant financial investments to improve HCAHPS scores, this healthcare system was not seeing the benefits of their efforts.

The 2013 CMS implementation of value-based purchasing links hospital reimbursement to quality metrics, as well as to the patient ratings of the care experience (McClelland & Vogus, 2014). Hospitals are incentivized based on the quality and care they provide. Third-party payers measure patients' perception of the care they receive, and it is impacting hospital reimbursement. The CMS (2017) publicly reports information that allows comparisons to be made across all hospitals to support consumer choice. For the hospital's reputation, coupled with the financial impact on the hospital, patient satisfaction must be taken seriously.

In 2016, the organization's executive leadership decided to pilot two optimization hospitals, providing them with a full-time care experience leader (CEL). In 2017, an

improvement in HCAHPS overall summary star score was noted at those facilities. The organization's executive leadership decided to approve a full-time CEL for all 21 hospitals in the NCAL region. Surprisingly, the investment did not prove to make a difference; in fact, there was a decrease in the HCAHPS summary star from 3.2 to 3.0 from September 2017 through June 2018.

Nurse leaders in this healthcare system rely on approximately 25,000 nurses in 21 hospitals located across the NCAL region to always provide exceptional care. The organization is experiencing rapid changes, and nurse leaders have a huge responsibility to produce results. The day of commanding and directive leadership has proven to be ineffective. Care experience scores are primarily nurse-driven, and nurse leaders must find new and innovative ways to improve and sustain care experience scores. The importance of connecting purpose to the *why* and practice to the *what* must be explored.

In the early spring of 2010, nursing leadership within this NCAL Patient Care Services (PCS) division embarked on a journey to embrace and incorporate core concepts of Watson's human caring science theory into the practice, environment, and culture of the organization. Caring science is built on the philosophy of human caring. According to Watson (2008), "Caring science is the starting point for nursing as a field of study offers a distinct disciplinary foundation for the profession; it provides an ethical, moral, values-guided meta-narrative for its science and its human phenomena, its approach to caring-healing-person-nature-universe" (pp. 15-16). Preserving human dignity, relationships, and integrity through human caring is ultimately the measure by which patients evaluate their often cure-dominated experiences (Watson, 2008).

Developing a model designed to actualize the caring theory, reinforce best practices that promote patient satisfaction, and transform the cultural norms is more important than ever for this NCAL healthcare system. Santos et al. (2014) found that connecting nursing best practices with a caring theory improves patient outcomes, such as care experience and quality metrics. The evidence-based change of practice project took place initially in a 120-bed, urban hospital.

Available Knowledge

According to Watson (2012), "The more individual and authentic presence the feelings are that the nurse conveys, the more strongly does the caring process affect the recipient" (p. 81). The project was initially influenced by the need to understand and explore how to help nurses connect back to their purpose so that patients feel cared for. Caring is the essence of nursing (Watson, 2008), and we cannot allow caring to simply wane away from our foundation.

A literature review was conducted using the search terms *HCAHPS, caring science, care experience, caritas, empathy,* and *nurse.* A search of the evidence was conducted using the criteria English language and authored during 1995 to 2019. The following databases were accessed for the literature search: PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Cochrane. Articles meeting inclusion criteria included those that (a) utilized Jean Watson's theory to improve care experience, (b) referenced compassionate care and the impact on patient's perception, (c) discussed the importance of knowledge of theory, or (d) referenced education of theory and outcomes. The Johns Hopkins research and non-research evidence appraisal tools were used to assess the strength and quality of the evidence (Dang & Dearholt, 2018). The articles were reviewed, and a synthesis table was created to support critical appraisal (see Appendix A: Evaluation of Evidence Table).

The PICOT question explored in this literature review was: In acute care registered nurses and patient care leaders (P), what is the effect of coupling care experience best practices with Jean Watson's human caring theory (I), compared to no caring theory (C), on the overall summary star HCAHPS score (O) within six months of implementation (T)?

Nurse Communication

McMillan (2017) provided an educational presentation on Jean Watson's human caring theory to frontline nurses among five units in a 468-bed facility. After the presentation, the nurses were encouraged to incorporate Watson's caritas processes into their practice and to create caring moments with their patients. HCAHPS results were analyzed for the five units eight weeks following the education session. The results were in the 95th percentile for the nurse communication domain, with an increase of 43% from the previous 52nd percentile prior to the education sessions. This project demonstrated that by incorporating caring behaviors into practice and creating caring moments, nurse communication scores could significantly increase. "Caring moments come before and after us, they linger and transcend in time" (Jean Watson, personal communication, October 17, 2019).

Interdepartmental Caring-Based Approach

Caring is not limited to nurses; patients encounter numerous individuals in addition to nurses, and each role and individual influences the patient's perception of care. Dudkiewicz's (2014) study determined that providing an in-service to ancillary services on Jean Watson's theory of human caring had a positive effect on patient satisfaction. Forty patients completed the Caring Behavior Assessment (CBA) questionnaire, 20 patients pre-intervention and 20 patients post-intervention. The in-service proved to be successful, with the satisfaction level statistically significant (t = -2.61, p = 0.013) and improvements post-education (M = 4.7, SD = .44), as

compared to pre-education (Dudkiewicz, 2014). Dudkiewicz concluded that providing education on caring behaviors and its meaning to all hospital staff on an ongoing basis is necessary in order to change the culture of an institution. Leaders should lead by example, set clear expectations, and reinforce the foundation of Jean Watson's human caring theory concepts when interviewing, hiring, orienting new employees, and during annual reviews.

Caring Behaviors

Suliman, Welmann, Omer, and Thomas (2009) concluded that 97.2% of the patients they studied rated overall caring behaviors as important, but only experienced caring behavior 73.75% of the time. Suliman et al. found that the difference between the importance of and frequency of attendance to caring behaviors by nurses was statistically significant (t = -4.689, p = .001), suggesting a disconnect between what patients need and what nurses are providing. Compassionate care matters more than ever, as patients begin to play an active role in choosing where they want to receive care. Watson (2008) shared that love and caring together invites a practice of deep transpersonal caring, and the relationship between the two creates an alignment and access for inner healing for self and others. According to Watson, "Love is the highest level of consciousness and the greatest source of all healing in the world" (p. 40). When we bring together love and caring into our practice, we discover and affirm that nursing is more than just a job; it is a life-giving and life-receiving profession that has much more to offer humankind (Watson, 2008).

McClelland and Vogus' (2014) cross-sectional study used the American Hospital Association database to draw a random sample of 269 nonfederal, acute care hospitals and used a key informant approach to assess compassion practices. They found that compassionate care by nurses directly impacted the overall hospital rating, resulting in patients who said they would

definitely recommend the hospital on the HCAHPS survey. The results showed that compassion practices were positively related to top-box hospital ratings (B = 0.128, $p < .05$). Compassion is the nurse's ability to be authentically present in a way that touches others transpersonally (Watson, 2008).

A transpersonal caritas consciousness nurse is more open and able to enter into and stay within the other person's frame of reference. The caritas conscious nurse attends to what is most important for the person behind the patient and the procedure. The nurse is present in the now, in this moment, and the care that is offered becomes more fulfilling for both the nurse and patient. Kornfeld (2002) shared, "When we come to rest in the great heart of compassion, we discover a capacity to bear witness to, suffer with, and hold dear with our own vulnerable heart the sorrow and beauties of the world" (p. 103). McClelland and Vogus (2014) claimed that patients' perception of the care they receive directly impacts hospital reimbursements, incentives, and reputation. Healthcare organizations must find ways to connect care experience best practices with creating and sustaining a compassionate culture in order to meet the needs of our patients and reach quality, care, and fiscal goals.

Leadership

Winter Haven Hospital experienced significant turnover in nursing leadership at the executive level. In addition, the hospital had a registered nurse (RN) vacancy rate of 40% and a 70% turnover rate for nurse leaders (Schlagel & Jenko, 2015). Through these difficult times, a certified nurse specialist (CNS) helped sustain the nursing department by using Watson's caring theory to guide and ascertain authentic transpersonal caring relationships with patients, with the patients' families, and with each other. Jean Watson stated, "We are the light in institutional darkness, and in this model, we get to return to the light of our humanity" (personal

communication, March 20, 2018). Despite the lack of nursing leadership and nurse turnover, the nursing department was able to continue to improve the quality, care, and financial outcomes of the hospital. The CNS was recognized for being a passionate leader who supported and led the caring theory and was later promoted to chief nursing officer (CNO; Schlagel & Jenko, 2015).

Quality and Care Experience

Taylor et al. (2008) conducted a 3-month prospective cohort study of 228 adult inpatients who were interviewed during and after their admission to assess the problems they encountered during their hospitalization. Service quality deficiencies reported during the surveys were then compared to adverse events, close calls, or low-risk errors found through chart audits. Twenty-one percent of the hospitalized patients studied experienced at least one adverse event, close call, or low-risk error, while patients who experienced service deficiencies were 2.5 times more likely to experience a clinical event (Taylor et al., 2008). The results of this study suggest that service quality deficiencies were also associated with adverse events and medical errors. The incongruity between the professional values and behaviors of healthcare professionals is serious and was shown in this study to be linked to poor healthcare outcomes (Taylor et al., 2008). The application of human caring theory with care experience best practice and the professional practice model offers possibilities for caring-healing-protective environments.

Knowledge of Theory

Santos et al. (2014) used the descriptive qualitative approach to discover what enables nurses to and deters nurses from carrying out Watson's theory with families of pediatric patients. The study was carried out in three stages. The first stage included a 4-hour presentation that educated the nurses on the theoretical content and provided material they could keep for future reference. The second stage encouraged nurses to implement the content they learned and utilize

the material while interacting with families. During this phase, which lasted 60 days, researchers were available to answer questions, clarify the theoretical framework, and clear up any doubts the nurse may have had. In the third stage, interviews were conducted with 12 nurses who had agreed to be part of the study (Santos et al., 2014). Through an inductive thematic analysis, the researchers identified three themes: identifying a caring framework, relationship challenges with families, and contemplating institutional context (Santos et al., 2014). The authors concluded that the nurses did not understand the caring framework. However, the nurses understood the importance of creating better interpersonal relations with the family, and they realized that incorporating Watson's theory into their practice would be beneficial not only for the patient but also for themselves (Santos et al., 2014).

Caring Theory and Results

The University of North Carolina Hospitals (UNCH) operationalized Swanson's caring theory and changed practice to sustain high-performance results (Tonges & Ray, 2011). The UNCH healthcare organization created the Carolina Care Model to actualize Swanson's caring theory and to support practices that promoted patient satisfaction. This model incorporated core behaviors and practices that helped discern Swanson's theory into practice. When comparing data from 2008 to 2010, there was an increase in overall patient satisfaction from 83.7 to 86.1, nursing satisfaction from 88.7 to 89.6, pain control from 85.4 to 87.8, and responsiveness from 86.0 to 87.6 (linear mean). Results indicated a substantial improvement in care experience scores that had been previously flat for over six years. The most noticed improvement was in pain control and response to call lights (Tonges & Ray, 2011).

Regardless of what nursing theory is used, it is the interrelationship between nursing theories and nursing practice that frame thinking, action, and being in the world. The major

reason for the development and study of nursing theories is to improve nursing practice and, therefore, the health and quality of life of those we serve (Smith & Parker, 2015).

Based on the review of literature, there appears to be an unbridgeable disparity between what patients need and what nurses are providing. This incongruity between the knowledge of values, theory, and behaviors of healthcare professionals is noticed by patients and reflects on poor quality and care experience outcomes. The literature review supports that triangulating care experience best practices, a professional practice model, and a caring theory could improve overall care experience and quality outcomes in a healthcare system.

Rationale

The overarching framework for this project was Jean Watson's theory of human caring. The major conceptual elements of the original and emergent theory are as follows:

- 10 carative factors (transposed to 10 caritas processes)
- Transpersonal caring moment
- Caring consciousness/intentionality and energetic presence
- Caring-healing modalities (Smith and Parker, 2015, p. 323).

The 10 caritas processes provide the structure and language necessary to frame the core aspects of nursing care (see Appendix B: Ten Caritas Processes). Caritas originates from the Latin word meaning "to cherish and appreciate, giving special attention to, or loving" (Watson, 2008, p. 39). Connecting love and caring together invites a deep form of transpersonal caring and creates an alignment and access for inner healing for self and others. According to Watson (2008), "Love is the highest level of consciousness and the greatest source of all healing in the world" (p. 40). When we incorporate love and caring in our work and our lives, we realize and affirm that nursing is more than a job, "It is a life-giving and life-receiving career for a lifetime

of growth and learning" (Watson, 2008, p. 40). Nursing helps nourish human dignity and humanity itself, while adding to the evolution of human consciousness, helping to shift toward a more humane and caring moral society and civilization that is so desperately needed in the world right now.

Incorporating Jean Watson's human caring theory with care experience best practices, and a move in the caring theory from a conceptual to an operational level directly impacted the overall HCAHPS summary star score in a small urban hospital in the NCAL region. This was done through intentional, creative strategies that created an authentic culture of caring through coupling care experience best practices with Jean Watson's human caring theory, starting with self.

Due to the several phases of this project, there was a need for utilization of several frameworks implemented for this project. Connecting Jean Watson's human caring theory with the NCAL professional practice model and care experience best practices are believed to have been the foundation to effectively improve the care experience in several hospitals in NCAL.

Conceptual Framework

The frameworks of Jean Watson's human caring theory; inspiration, infrastructure, education, and evaluation (I2E2); Kaiser Permanente's Voice of Nursing; and Roger's diffusion of innovation theory guided the project and purpose of the *Nursing Practice Meets Theory* training. The training was intended to help nurses and nurse leaders integrate caring behaviors into their daily practice, ultimately improving the patient's perception of care. The utilization of these frameworks allowed for the potential emergence of more caring nurses and nurse leaders.

Inspiration, Infrastructure, Education, and Evaluation

I2E2 is a method for change developed by Felgen (2007). This framework was used to facilitate engagement of stakeholders by focusing on the desire to transform cultural norms that move the caring theory from a conceptual to an operational level.

Inspiring caregivers is the foundation for shifting the culture from a curing culture to a caring culture. When we touch another person physically, we are touching more than just their body, we are touching their mind, their heart, and their soul (Watson, 2008). Throughout the training, the author used the human caring theory to inspire caregivers to reconnect back to purpose and guide caring practices. Infrastructure establishes the processes, systems, and structures necessary to achieve this goal and provides the structure for the ongoing work (Felgen, 2007). The infrastructure of this project was originally tested in a small urban hospital. Because the project was proven to be successful, the author was asked to repeat the training in an additional hospital in NCAL.

The education of the human caring theory was done with the inpatient PCS team. This training incorporated the core elements of Jean Watson's human caring theory with the fundamental four care experience best practices. The evidence showed that the concept was successful. The evidence was the improvement of HCAHPS summary star within three months of implementation.

Professional Practice Model: Voice of Nursing

The I2E2 framework is used in this NCAL healthcare system's professional practice model called the Voice of Nursing (VON). The VON focus is to enhance the professional practice of nurses and to promote a culture that values professional practice and accountability (Kaiser Permanente, 2013). This practice model is designed to unite and align all nurses under one vision and set of values across the organization (Kaiser Permanente, 2013). The VON, the

professional practice model of this healthcare system, was the perfect forum to introduce and structure the concept of transforming cultural norms that move the caring theory from a conceptual to an operational level.

Change Framework: Rogers' Diffusion Theory

Rogers' (2003) diffusion of innovation theory describes the innovation-decision process as "an information-seeking and information-processing activity, where an individual is motivated to reduce uncertainty about the advantages and disadvantages of an innovation" (p. 172). There are five steps in the innovation-decision process: (1) knowledge, (2) persuasion, (3) decision, (4) implementation, and (5) confirmation.

The knowledge stage is when the individual learns about the existence of innovation and seeks information about the innovation. In this stage, the author attempted to determine "what the innovation is and how and why it works" (Rogers, 2003, p. 21). During this stage, the author was introduced to Jean Watson's theory and had the desire to learn more about caring theory. With a combination of 32 years' experience in healthcare and as a certified caritas coach, the author was able to connect the *practice* (care experience best practice*s)* to *purpose* (Jean Watson's human caring theory*)*. This is important because an individual can have the knowledge about an innovation, but it does not mean that the individual will be able to incorporate it into practice. The individual's attitudes toward the innovation can either adopt or reject the innovation. The author embraced and adopted this innovation and incorporated the theory into her own practice.

In the persuasion stage, the individual is involved more sensitively. The social reinforcement from colleagues and peers influences the individual's opinions and beliefs about the innovation. During this phase, socializing the idea is important. The individual wants to

seek feedback and support from others to feel confident about moving forward with the concept or project. This was an important phase for this author. Since this was a new concept, achieving results was imperative to receive continued support. The approval to move forward with the training had to come from someone who was not familiar with the theory. The author was able to show positive results very quickly, which helped to obtain regional support to continue this work and spread.

During the decision stage, the innovation can either be adopted or rejected. This project was done in a small urban hospital first and was proven successful. In this second phase, rejection is possible in every stage of the innovation-decision making. Since it was proven to be successful, the concept was rolled out on two units in a second hospital in NCAL. In addition, the author has been charged to lead the efforts on incorporating the theory into trainings and teach the theory on a monthly basis at the CEL peer-group regional meetings.

The implementation stage is when the innovation is put into practice. During this stage, the individual will need assistance from others to reduce the uncertainty. Reinvention is important in this phase. Reinvention is "the degree to which an innovation is changed or modified by a user in the process of its adoption and implementation" (Rogers, 2003, p. 180). The more reinvention takes place, the quicker the innovation becomes adopted and institutionalized. Since this had not been done in any NCAL region hospital, the author reinvented the concept throughout the implementation stage to adapt to the needs of the recipients, priorities, and desired outcomes. During the implementation stage, there were many barriers to overcome, which included significant turnover in both facilities, competing priorities, new nurse leaders, lack of understanding of theory, and drifting of practice. Despite these barriers, both facilities did see an improvement in HCAHPS scores.

Specific Aims

The primary aim of this project was to develop, implement, and evaluate the operationalization of a caring theory with frontline RNs and PCS leaders to improve the patient's experience in a healthcare setting. This was accomplished by coupling care experience best practices with the core concepts of Jean Watson's human caring theory. The desired outcomes of this project included:

1. Nurses and nurse leaders will exhibit authentic caring behaviors through the integration of Jean Watson's caring theory by providing structure and language to define, enlighten, support, and influence the professional nursing practice, as evidenced by an improvement in summary star rating of 2.8 to 3.1 in six months of implementation of training (Ryan, 2005).
2. The small urban facility will experience an increased HCAHPS summary star score from 2017 baseline of 2.8 to 3.1 within six months of implementation of the training.

Section III. Methods

Organizational Content

Caring Science Theory and Programs

In 2008, the organization adopted Jean Watson's theory of human caring systemwide and began the journey to integrate and spread the concepts of caring science. The vision was communicated and celebrated, but with the changes in healthcare, competing priorities, leadership turnover, and a decrease in enthusiasm, the integration and spread diminished overtime.

Caritas Coach Education Program

This Caritas Coach Education Program (CCEP) is an innovative 6-month professional development program that incorporates interactive online education with a caritas coach faculty member. Through this training, the student explores caritas consciousness and ways of knowing-being-doing-becoming, which prepares the student to transform their personal and professional life practices toward deeper meaning, purpose, dignity, and wholeness (Watson Caring Science Institute, 2018).

In 2016, the author graduated from the CCEP and became a certified caritas coach. During this journey, the author identified the importance of connecting Jean Watson's theory of human caring with care experience best practices. After 30 years of nursing, 17 of those years as a nurse executive, the author had new insight, intellect, and skills to give voice to the concept of *living caritas*. The author was able to identify ways on how to relate the theory and philosophy of human caring-healing for the inpatient care team by understanding the connection and importance of operationalizing Jean Watson's human caring theory to help nurses reconnect to purpose.

There have been 80 caritas coaches in the healthcare system trained since the program began in 2010. Currently, there are 66 in the medical centers, 10 in the region, three in the call center, and one in Home Health. This includes one assistant chief nurse executive, five CELs, and two CNEs.

International Caritas Consortium

This large integrated healthcare system hosts an annual conference, where Jean Watson comes to the consortium and speaks about aspects of the theory. The main purpose of the International Caritas Consortium Charter is:

1. To explore diverse ways to bring the caring theory to life in academic and clinical practice settings by supporting and learning from each other.
2. To share knowledge and experiences so that we might help guide self and others in the journey to live the caring philosophy and theory in our personal and professional lives. (Watson, 2008, pp. 278-280)

Caritas Committee

The caritas committee was created in 2016 and is comprised of 15 nurses. The meetings are held once a month in this small urban hospital. It is the only caritas committee in NCAL made up of RNs from all areas of the hospital. Their mission is to practice the caring theory and lead by example as caritas advocates. The author is a certified coach and an active member of this committee and provides guidance and support to the group in their deeper connection and understanding of Jean Watson's human caring science.

Intervention

Context

As discussed earlier, a large, integrated, not-for-profit healthcare system in the NCAL region witnessed a decrease in their HCAHPS summary star rating. The HCAHPS survey is composed of 22 questions that encompass critical aspects of the patient's hospital experience and is publicly reported. The care experience analytical tool showed September 30, 2019 that this healthcare system in the NCAL region was averaging a summary star score of 3.0, compared to 2017 baseline of 3.2 (Mingming, 2018). Despite the significant financial investments to improve HCAHPS scores, this healthcare system has not seen the benefits.

In the context of the decreased region-wide HCAHPS scores, the author of this project, a DNP student, CEL, HeartMath trained, and caritas coach, proposed the concept to hospital leadership of exploring ways to operationalize Jean Watson's human caring theory with care experience best practices. No hospital in this healthcare system has a formalized model designed to actualize Jean Watson's human caring theory to improve patient satisfaction. This project was tested in a 120-bed, urban hospital, with an average daily census of 65, located within a large healthcare system in NCAL.

The author conducted a 2-hour mandatory educational program with all inpatient nursing staff that reviewed the major conceptual elements of Jean Watson's human caring theory with care experience best practices. The converging of these two concepts has improved outcomes and the perceptions of care experiences (see Appendix C: Convergence Care Experience and Caring Science). This initial training was the foundation for all future work. The classes were mandatory for all inpatient RNs and patient care technicians (PCTs). The desired outcome was proven to be successful, the overall HCAHPS summary star moved from baseline of 2.8 to 3.1

within three months of implementation and was sustained for 15 months, despite a significant turnover in the PCS department. Since the training was proven to be successful, the formalized training was used in other hospitals in this NCAL system.

Key Stakeholders

As a result of discussions with the chief operating officer/chief nursing officer (COO/CNO), primary stakeholders for the program was identified and planning for the caring science training began in March of 2018. The stakeholders included approximately 230 PCS employees, which encompassed PCTs, RNs, and nurse leaders in the inpatient units.

Responsibility/Communication Matrix

The strategic messaging for this project outlined the commitment and communication strategy across all levels of the stakeholders. The messaging was intentional and concise, with an overview of the importance and goal of connecting Jean Watson's human caring theory with already established care experience best practices to improve patient satisfaction. Stakeholder roles were reviewed, and a commitment was obtained to move forward with training. Communication was diverse, and several different avenues of communication were used throughout the communication phase, such as emails, phone calls, one-on-one conversations, conference calls, meetings, and scheduled training (see Appendix D: Responsibility/ Communication Matrix).

Gap Analysis

A gap analysis was done through observation and conversations with nurses and nurse leaders and revealed that the stakeholders lacked knowledge of Jean Watson's human caring theory. All the nurse leaders, including the COO/CNO, were new to the organization and had no formal training or education on the theory. The hospital had not had a full-time CEL in over

seven years, and it was evident that minimal attention was put on hardwiring care experience best practices. It was found that there was a huge gap in the knowledge base around several key factors. These key factors included understanding how to read the HCAHPS scores, what best practices were needed to improve key components of the HCAHPS questions, and their individual roles and responsibilities around the care experience, NCAL nursing theory, and the impact on reimbursement and reputation HCAHPS had on the organization. The overall summary star score showed that the facility was at a baseline of 2.9 in 2017. With a baseline of 2.8 as of March 2018, it was clear that incorporating the core concepts of the caring science theory with a review of the care experience best practices with the inpatient PCS team was imperative (see Appendix E: Gap Analysis).

GANTT Chart

A project GANTT chart was created to function as a reference guide for the program planning, for monitoring critical milestones, and to capture work that was done (see Appendix F: GANTT Chart). Detailed steps were outlined for future implementations. The total project timeline, from the analysis to the completion of the project, was six months. There were several different phases of this project. An initial assessment was done to determine the knowledge level of caring science and compliance on care experience best practices. A core committee of stakeholders was formed to review data, identify areas of opportunity to improve care experience scores, create and commit to action plans, monitor progress, and hold teams accountable for execution of plan.

The creation and development of the education plan were done after assessment of core competencies and knowledge of theory. The training took six weeks to complete and included the review of the major elements of the human caring theory and the fundamental four care

experience best practices. During the classes, as the CEL, caritas coach, and nurse, the author attempted to inspire and reconnect the inpatient PCS staff back to their purpose as a professional nurse by incorporating Jean Watson's human caring theory into their practice. The developed 2-hour mandatory training was done with the inpatient PCS team. Simultaneously, nurse leaders attended an 8-hour training that focused on the human caring theory, coaching, and mentoring and included feedback for encouraging excellence provided by the author.

Validation of the training was done by the author and nurse leader at the bedside, which included nurse knowledge exchange, hourly rounding, nurse leader rounds, and observation of nurses incorporating the core elements of caring science into their practice. The goal was to recognize and reward the observation of caring behaviors and compliance of care experience best practices. Immediate feedback, coaching, and mentoring were provided in any of the elements were missing during the validation.

A recognize-and-reward program was implemented and created a spirit of pride with the staff. Every other month, the care experience committee members would identify a unit or department that showed an improvement on their HCAHPS scores, had increased positive verbatim comments, or was nominated by one of the committee members for showing positive caring behaviors. The committee would take a trophy bowl filled with snacks to the department and congratulate and reinforce positive caring behaviors. Pictures of the team were taken and sent to the service areas' public relations department and published in the monthly newsletters. Reward and recognition were key factors in nurturing a caring culture at the bedside. Bright (2017), a Studor Group Coach, stated that "Reward and recognition fuels healthcare professional's passion. And that's a game-changer" (p. 2).

The author joined the hospital's caritas committee. The committee was made up of bedside nurses who see themselves as caritas nurses. This provided the author a forum to further teach those who were interested in Jean Watson's human caring theory and to obtain support and input from the nurses who did the work.

Work Breakdown Structure

The following areas were identified as key initiatives for developing the program and served as the project level descriptions for the work breakdown structure (see Appendix G).

1. Planning
2. Content development
3. Supplies and technology
4. Attendees
5. Budget

Planning. Planning at the project level included obtaining support from the executive team at the facility. The plan was shared with nurse leaders to gain their support. Once approval was obtained, dates and conference rooms were secured. The literature review was done for best practices, and content was created for training purposes. Thirty classes were scheduled, and all inpatient PCS employees were required to attend one 2-hour class. The educational HealthStream system was used for employees to sign up and to track attendance.

Content development. An analysis of the HCAHPS scores for this facility was completed, and areas of opportunities were identified. The content incorporated care experience best practices with the caring theory for each composite on the HCAHPS survey. There was an emphasis and focus on any composite that had a summary star of 2.0 or below. For example, the composite *quiet at night* is at a summary star of 1.0. The CEL reviewed the question on the

survey and then connected it to Caritas Process 8: Creating a healing environment at all levels. A dialogue took place with the audience on why being quiet was important in a hospital setting. The class content showed a constant connection between the HCAHPS survey question, caring theory, and care experience best practices.

Supplies and technology. Technology needs included equipment to support a PowerPoint presentation, including a laptop, LCD projector, and power cords. Flyers were made to distribute throughout the inpatient nursing units to promote the class and to notify staff that the class was mandatory. HealthStream was used for each employee to sign up for specific dates when the classes were offered. HealthStream allowed the author to anticipate how many employees would be attending each class in advance and to track compliance.

Attendees. There are approximately 230 PCS employees in the inpatient units; which includes RNs, PCTs, and nurse leaders. There was a 90% attendance rate. The goal was to obtain engagement by inpatient caregivers and allow for authentic dialogue to take place, allowing for curiosity and openness to the concept.

SWOT Analysis

A SWOT (strengths, weaknesses, opportunities, and threats) analysis was developed to provide a summary and a visual of the project. The goal was to share with the executive team the strengths and opportunities, while gaining support to address and control for potential weaknesses and threats (see Appendix H: SWOT Analysis).

Strengths included a very noticeably engaged nursing staff who innately had caring behaviors displayed during the initial assessment and validation period. This facility's average daily census is 65, and it is one of the smaller hospitals in the region. Historically, this hospital was one of the higher-ranking hospitals in care experience in the NCAL region. The current

CEL has 32 years of healthcare experience, with 17 years of chief nursing experience. The CEL is also a caritas coach and understands not only the caring theory but also how to operationalize care experience best practices with caring science. In addition, the region provides a tremendous amount of data, which are useful to help improve care experience at this facility.

Opportunities exist to strengthen the knowledge and understanding of caring science and how one can operationalize this theory to improve the care experience with patients and families in this NCAL health system. Through developing and nurturing relationships and helping to connect purpose to task, the perception of care could improve and ultimately impact HCAHPS scores. In addition, recruiting and retaining staff would provide stability, continuity of care and the ability to cultivate and sustain care experience best practices.

Weaknesses included a lack of understanding of what the CEL does, and many see this position as the person who solely improves care experience in the hospital. The CEL has no authority and can only affect change through influence of others to do the work. The CEL in this facility is the only one who is not on the executive team in NCAL; therefore, others do not see the CEL as part of the senior leadership team. With competing priorities, care experience is not a priority for many leaders and executives at this facility. Other weaknesses included the facility is very old and tired. The rooms are extremely small, and units are cluttered, creating inefficiencies for the PCS team. This facility was one of the last facilities to recruit a CEL; therefore, most other NCAL hospitals were ahead in practice and scores.

Threats included the impact that turnover of nurses and nurse leaders would have on sustaining the caring culture that has been created, in addition to the nurse leader's ability and understanding of caring science and best practices to carry out this work. The ability of the nurse

leader to cultivate and sustain this work due to competing priorities needed to be taken into consideration.

Budget

The total cost of this initiative was $44,465. This included two hours of training for approximately 198 employees, which included 188 RNs, 10 PCTs, and eight hours of training for 15 assistant nurse managers. Supply costs were $45, which included paper, ink, and staples (see Appendix I: Budget). The author spent approximately 95 hours teaching the classes over a six-week period.

Outcome Measures

The outcome measure chosen for studying the processes and outcomes of the intervention was the HCAHPS survey. The HCAHPS survey is composed of 22 questions, 19 of which encompass critical aspects of the patient's hospital experience (CMS, 2017). The CMS publicly reports information that allows comparisons to be made across all hospitals to support consumer choice (see Appendix J: HCAHPS Survey Questions). The outcome was that the facility experienced an increased HCAHPS summary star score from 2017 baseline of 2.9 to 3.1 three months after training.

Analysis

The analyses consisted of quantitative and qualitative information obtained from the weekly HCAHPS data analyses tool and the nurse comments after training. The HCAHPS survey results were analyzed weekly, with reports being provided with up-to-date scores for each facility (see Appendix K: Data Analysis Tool). During the monthly strategy meeting, HCAHPS scores were reviewed, and action plans were developed for any composite that was not improving or showed a decline. For example, nurse communication score showed a decline in

scores, and the group agreed that a more diligent oversight of nurse leader, hourly rounds, and bedside report would be made. In addition, huddle messages were created to remind staff and leaders on the importance of care experience best practices, along with the *why* of ensuring safe quality care.

There was a constant connection between theory and practice. The three questions on the HCAHPS survey for nurse communication are: Did the nurse explain things to you in way that you could understand? Did the nurse listen to you? Did the nurse treat you with courtesy and respect? The author created huddle messages for the nurse leader to share with the staff on the importance of *authentic presence* (Caritas 1) and *engage in genuine teaching* (Caritas 7), along with a reminder of the importance of hourly rounds, bedside report, and nurse leader rounds.

Approval for further training was predicated on the improvement of HCAHPS scores and positive comments received by nurses post-training. Due to the success of the pilot hospitals the author was asked to work with two additional facilities.

Ethical Considerations

Organizational approval was obtained from the regional director of care experience in August 2018. The DNP statement of non-research determination was submitted to the University of San Francisco School of Nursing and Health Professions DNP program and was approved as a quality improvement project (see Appendix L: Non-Research Determination). The HCAHPS results are publicly reported for anyone to view on the CMS Hospital Compare website. This author did not anticipate any ethical issues regarding the data collected or shared.

Jesuit Values

The Jesuit principle that is consistent with the values of Jean Watson's caring theory is *contemplatives in action*. This principle helps in a person's ability to return to a baseline state

after a stressful event and aids in mitigating the effects of persistent stress (Streetman, 2015). Otto (2013) shared that contemplation allows us to renew our lives, repeating the cycle by stopping, resting, reflecting, and then returning back to purpose. Watson's (2008) practice of loving-kindness and equanimity for self and others is foundational to the caritas practice; one cannot engage in and sustain caritas practices for caring without being personally prepared. This practice requires nurses to attend to self-caring practices that assist in their own evolution of consciousness for more fulfillment, so they are able to sustain others. They both guide an individual to care for self so that one is prepared to care and be for others.

American Nurses Association Code of Ethics for Nurses

The American Nurses Association (ANA) Code of Ethics for nursing provides a succinct statement of the ethical values, obligations, and duties of every individual who enters the nursing profession and serves as the profession's nonnegotiable ethical standards (Olson & Stokes, 2016). Jean Watson's theory places human-to-human caring as central to the professional nursing responsibilities and roles as the moral foundation for the profession (Watson, 2008). The caring theory guides nurses in maintaining human dignity, relationships, and integrity through human caring. The ANA (2015) Code of Ethics also guides nurses in their obligation to be consistent with quality in nursing care and to practice ethically. Provision 1 of the ANA Code of Ethics speaks to practicing with compassion and treating patients with dignity and worth (Olson & Stokes, 2016). Provision 1 connects with Jean Watson's Caritas Process 1, practicing loving-kindness with equanimity toward self and others (Watson, 2008).

Section IV. Results

Method of Evaluation

HCAHPS Star Rating Methodology

CMS publishes HCAHPS star ratings on its Hospital Compare website. Ratings make it easier for consumers to use the information on the Hospital Compare website to spotlight excellence in healthcare quality. Eleven HCAHPS star ratings appear on Hospital Compare, one for each of the 10 publicly reported HCAHPS measures, plus an HCAHPS summary star rating. The star rating is updated each quarter.

The HCAHPS survey is administered to a random sample of adult patients across all types of medical conditions between 48 hours and six weeks post-discharge. Hospitals must receive at least 100 completed HCAHPS surveys quarterly to be eligible for public reporting measures on Hospital Compare. The calendar year for HCAHPS is October 1 to September 30.

CMS assigns stars for each measure by relating statistical methods that consider the comparative distribution and clustering among all responses. The ratings are then adjusted for the effects of the patient mix, survey mode, and quarterly weighting. Scores are then rounded up to the nearest whole number then a summary star rating is assigned for each hospital (HCAHPS, 2019a).

HCAHPS Measures

HCAHPS star ratings are applied to each of the 10 publicly reported HCAHPS measures. Measures are created from specific questions on the HCAHPS survey, as follows:

HCAHPS Composite Measures:

1. Communication with Nurses (Q1, Q2, Q3)
2. Communication with Doctors (Q5, Q6, Q7)

3. Responsiveness of Hospital Staff (Q4, Q11)
4. Communication about Medicines (Q13, Q14)
5. Discharge Information (Q16, Q17)
6. Care Transitions (Q20, Q21, Q22)

HCAHPS Individual Items:

7. Cleanliness of Hospital Environment (Q8)
8. Quietness of Hospital (Q9)

HCAHPS Global Items:

9. Hospital Rating (Q18)
10. Recommend Hospital (Q19; HCAHPS 2019b)

Baseline Data

First pilot. In the small urban facility, pre-intervention summary star scores in March 2018 were 2.8; compared to the other 21 facilities in NCAL, this facility ranked 15th. Training began mid-March 2018. Ninety percent of all inpatient PCSs attended the 2-hour training over four weeks. There was a total of 32 classes offered on all three shifts. In addition, a mandatory, 8-hour class was offered to the nurse leaders during this time period, with a 100% attendance.

Second pilot. In the larger urban facility, two units were identified to test the initial training to see if the results could be replicated from the first pilot at the small urban facility. In the first unit, 6 South, the pre-intervention summary star was 2.6. The second unit, 7 Central, pre-intervention summary star was 2.7. Training began November 2018, and 90% of inpatient PCS from those two units attended the 2-hour class. The training took approximately six weeks to complete. In addition, there was an 8-hour class offered to the nurse leaders from those two units during the same timeline, with 100% attendance.

Results

Quantitative Measures

In the first pilot hospital, significant results were seen within the first three months. Overall, summary star rating went from a baseline of 2.8 in March to 3.1 in June, in comparison to other hospitals, this was significant (see Appendix M). Within three months, the hospital moved from the lower left quadrant in the Watch Status Report to the top left in June 2018. This reflected a 10.7% gain.

In September 2018, six months post-training, the hospital ended the calendar year at an overall summary star rating of 3.1, 0.1 away from meeting their goal of 3.2 (see Appendix N). The last six months of the calendar year April 2018 to September 2018, the overall summary star was 3.5 (see Appendix O); this excluded all pre-training months.

As of September 4, 2019, 15 months later, this facility was able to sustain a summary star of 3.1 (see Appendix P), despite significant turnover in the PCS department. Since the project began, this facility is on it's third inpatient director, third medical surgical manager, and second intensive care/telemetry manager, which accounts for all of the inpatient units.

The author was asked in November 2018 by the area manager and the regional director of Care Experience to replicate the training on two units in another, larger urban hospital. At the other facility, the first unit (6 South) went from a baseline of overall summary star rating of 2.6 to 3.2 (see Appendix Q), and a second unit (7 Center) went from a baseline of overall summary star rating of 2.8 to 3.6, within three months implementation of training (see Appendix R).

Qualitative Measures

The training was well received by the participants. A 15-minute discussion took place at the end of each training. The author asked the participants to share one thing they were going to

do differently now that they had completed the training. Feedback on perceptions and responses to the training were captured in the following remarks:

- Thank you for making it okay to care again.
- I'm now to going pause and listen more.
- I'm going to reflect daily and try to remember my purpose.
- I'm not going to judge families who want to keep their elderly parents alive, even if I don't agree with their decision, I am going to support and not judge.
- We need more of this!
- This training should be done at least yearly, if not more.
- This is exactly what I needed.
- I'm going to connect with touch more and smile often.
- Do the managers and other leaders get this training? If not, they should.
- I'm going to try and be more authentically present when I am in the room with my patients.
- This was one of the best trainings I have ever had.
- Understanding and operationalizing Jean's theory can be difficult for some, you've done a great job explaining it so I can apply it to my practice.
- I definitely need to start taking better care of myself.
- Thank you, for sharing all your words of wisdom and giving me more inspiration to carry this into my daily practice.
- I believe this also carries into my daily life outside of the patient care setting. Every day I seek self-improvement and use this as the foundation.

- We are so fortunate to have you as a leader, mentor, and friend!! I look forward to our meetings.
- I so appreciate your zeal for care experience and our patients. Truly impressive.
- Caring science has given me the words to articulate caring in a way that I have not been able to do. Most importantly, it has given me permission to ALWAYS connect back to why we are here and what we are supposed to be doing.
- I've been here several years, and I have never seen these numbers move before (area manager).
- With this much turnover, it really is a miracle that we've been able to sustain these numbers (CNE/COO).

Section V. Discussion

Summary

Training was conducted in a small and a large urban hospital with a group of PCS employees and nurse leaders that aligned Jean Watson's human caring theory concepts with evidence-based care experience best practices. An analysis of the HCAHPS was done pre- and post-training. An improvement in overall summary star was noted post-training in both hospitals.

Consistent with project aims, outcomes reflected nurses and nurse leaders exhibiting authentic caring behaviors through the integration of Jean Watson's human caring theory into their professional nursing practice. Both facilities experienced an increase in HCAHPS summary star score within three months of implementation of training.

In the first pilot hospital, overall, summary star rating went from a baseline of 2.8 in March to 3.1 in June; in comparison to other hospitals this was improessive. Within three months, the hospital moved from the lower left quadrant in the Watch Status Report to the top left in June 2018.

In September 2018, six months post-training, the hospital ended the calendar year at an overall summary star rating of 3.1, 0.1 away from meeting their goal of 3.2. In the last six months of the calendar year April 2018 to September 2018,the overall summary star was 3.5, which excluded all pre-training months. As of September 4, 2019, 15 months later, this facility was able to sustain a summary star of 3.1.

At the second facility, the first unit (6 South) went from a baseline of overall summary star rating of 2.6 to 3.2, and a second unit (7 Center) went from a baseline of overall summary star rating of 2.8 to 3.6, within three months of implementation of training.

At the beginning of the training, the author reviewed the hospital's overall HCAHPS scores and each unit's scores and compared them to the other hospitals in the NCAL region. The staff was surprised and embarrassed that their scores were significantly lower than others in NCAL. This tactic proved to create a sense of urgency and the understanding that they needed to do something different than what they were doing. Occasionally, staff would make excuses that the reason for their low scores was because of the socioeconomic status of the community, staffing issues, number of surveys completed, and other things. The author had to navigate these assumptions carefully while making sure that the group understood that the patient's perception was their responsibility, despite any other factor.

At the end of each class, there was time to reflect upon the learnings. The author asked each person to share one thing they would do differently, do more of, or stop doing now that they had completed the training. This was done so that everyone would verbalize to the group and commit to incorporating at least one element of the theory into their practice. During this time of reflection, it was not unusual for staff to become emotional and share caring moments they had with their patients.

The increased and constant support of caring science and integration was further enhanced on the monthly agendas of nurse leader meetings, daily huddle messages with leaders, sharing of caring moments, and celebrating successes as the scores continued to improve. There was a sense of caring and connection with the nurses and nurse leaders as a result of the training, with continued dialogue about caring science, where they were able to authentically engage, cultivate, and sustain caring behaviors into their practice.

Through the engagement and support of the nurses and nurse leaders who practice and model the elements of caring science, the hospital was able to improve patients' perceptions of

care and increase overall HCAHPS summary star rating. Cultivating and sustaining these caring behaviors into clinical practice has helped maintain the improvement, despite the significant turnover in PCS. The outcomes of this training justify the spread into other NCAL facilities.

Interpretation

Overall HCAHPS summary star showed an improvement in both facilities post-training. Nurses and nurse leaders incorporated caring behaviors into their practice, and patients' perceptions of care improved. These findings are consistent with Watson's belief that "the more individual and authentic presence the feelings are that the nurse conveys, the more strongly does the caring process affect the recipient" (Watson, 2012, p. 81).

McClelland and Vogus' (2014) cross-sectional study used the American Hospital Association database to draw a random sample of 269 nonfederal, acute care hospitals and used a key informant approach to assess compassion practices. They found that compassionate care by nurses directly impacted the overall hospital rating, resulting in patients who said they would definitely recommend the hospital on the HCAHPS survey. This is consistent with the findings in both pilot hospitals. With the first pilot hospital, the question *recommend hospital* improved from a summary star of 3.0 in 2018 to a summary star of 4.0 in June 2019 YTD with closed data. In the second pilot hospital, 6 South unit went up one summary star in *recommend hospital,* from a 3.0 in 2018 to a 4.0 in June 2019 YTD closed data. The second unit, 7 Center, went up one summary star in overall *hospital rating,* from 3.0 in 2018 to a 4.0 in 2019 YTD closed data (see Appendix S).

During the training, the author discovered that a very small percentage of nurses actually was familiar with the nursing theory in NCAL; however, the verbatim comments the author obtained during the reflection portion of the training found that the nurses did find it valuable

and would incorporate key elements of the theory into their daily practice. This finding would align with Santos et al. (2014), who concluded that even though nurses did not understand the caring framework, they did understand the importance of creating better interpersonal relations with their patients and families, and they realized that incorporating Watson's theory into their practice would be beneficial not only for the patient but also for themselves (Santos et al., 2014).

Limitations

There are several key limitations that need to be mentioned. The data from the HCAHPS survey are lagged by 60 days; thus, intervention effectiveness was not known in real-time. High inpatient census is common during this period, and historically, a drop in HCAHPS scores is witnessed. Factors that contribute to a drop-in score are often due to the significant amount of traveling nurses, staff calling out sick, high RN turnover rate, and staff off for the holidays. The CEL has no authority or responsibility in ensuring that staffing is safe and adequate during this time. In addition, the nurse leader turnover rate can also affect the success of this program, as they are the ones who lead by example and ensure that practice is sustained. The CEL in the second pilot hospital was not a nurse and was in the process of obtaining his certification as a caritas coach.

During this time, a new acuity system was rolled out, and the change was difficult for some of the staff, which could have potentially impacted nurse morale. Nurse leaders spent a significant amount of time on learning and managing the new acuity system, which may have competed and interfered with their nurse leader rounds. Lastly, the training was done during union bargaining period, which could have distracted nurse leaders and nurses at the bedside.

Conclusions

For nurse leaders, an intensified demand for efficiency and financial responsibilities has shifted a culture from caring to curing. To meet these goals, nurses have become more task-oriented, which has led to progressively distant relationships between nurses and patients and a culture that has lost its way. The results of a noncaring culture are quality and safety violations and increased medical errors (Watson, 2008). Care experience scores are nurse-driven, and nurse leaders must move the theory from a conceptual level to an operational level in order to meet the obligations expected of them. A caring culture will not only impact the patient's perception of care but will create the foundation for a highly reliable, quality, safe organization that meets its financial goals, because nurses that care will do.

It has been thought that the implementation of a nursing theory can enhance caring practice by providing structure and language to articulate, support, and influence the professional practice of nursing. The training that was initiated in a small, 120-bed hospital as part of an evidence-based change of practice project demonstrated that the satisfaction of the staff and patients could improve. Since the program was successful in the first pilot hospital, it has been implemented in a second pilot hospital, and the author is currently implementing it in two additional facilities in NCAL.

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Section VII. Appendices

Appendix A

Evaluation of Evidence Table

Citation	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Variables Studied and Their Definitions**	**Measurement**	**Data Analysis**	**Findings**	**Appraisal: Worth to Practice**
Dudkiewicz (2014)	Jean Watson's Human Caring Theory	Questionnaire Survey, Caring Behavior Assessment (CBA)	Forty patients completed the Caring Behavior Assessment (CBA) questionnaire, 20 patients pre intervention and 20 patients post	Pre and Post results after presentation of Jean Watson's Human Caring Theory	Caring behavior assessment is made up of 63 caring behaviors based on Watson's theory of human caring.	Providing education on caring behaviors and what it means to all hospital staff, on an ongoing basis is necessary in order to change the culture of an institution. Leading by example, setting clear expectations, and reinforcing Jean Watsons human caring theory concepts should be considered from interviewing, orientation, to frequent in-services and annual reviews	The in-service proved to be successful, the satisfaction level had a statistically significant (t = -2.61, p = 0.013) improvement post education (M = 4.7, SD = .44) as compared to pre education	**Strengths:** Care experience involves all disciplines and just nurses. Positive results from patients post training **Limitations:** Does not discuss how it impacts HCAHPS **Critical Appraisal Tool & Rating:** JHNEB: III, A

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
McClelland & Vogus (2014)	N/A	Cross-sectional study	269 nonfederal acute care U.S. hospitals.	Compassionate practices, HCAHPS, management practices, patient's perception.	Survey collection from top-level hospital executives. Publicly reported HCAHPS data from October 2012 release. Utilized the HCAHPS questions: a) overall rating of hospital, b) likelihood of recommending the hospital to a friend or family member.	Comparison of respondents and non-respondent; descriptive statistics and correlations; weighted least squares regression analysis: Relationship between compassion practices and HCAHPS global measures. Compassion practices using five items (Cronbach's alpha=0.82) measured on a 1-7 Likert-type scale.	Compassionate practices, a measure of the extent to which a hospital rewards compassionate acts and compassionately supports its employees (e.g. compassionate employees awards, pastoral care for employees), is significantly and positively associated with hospital ratings and likelihood of recommending.	**Strengths:** Findings illustrate the benefits for patients of specific and actionable organizational practices that provide and reinforce compassion. **Limitations:** Hospitals in the sample size performed better on HCAHPS global measures than non-respondents. Study did not adequately sample for profit and lower performing hospitals to ensure the validity of results. **Critical Appraisal Tool & Rating:** JHNEB: III, B

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
McMillan (2017)	Jean Watson's Human Caring Theory	Questionnaire Survey (HCAHPS)	67 Nurses from 5 different units	Pre and Post results after presentation of Jean Watson's Human Caring Theory	Nurse Communication Patient satisfaction scores comparison between pre and post training.	Percentile of Nurse Communication Scores	HCAHPS Nurse Communication domain pre presentation was 53 percentile, post presentation 95 percentile, resulting in a 43% improvement	**Strengths:** Findings illustrate the benefits of training on theory and impact on patient's perception of nurse communication. **Limitations:** Results do not include sustainability or length of time it took to obtain. What if any best practices were implemented that could have influenced outcomes. **Critical Appraisal Tool & Rating:** JHNEB: III, A

Citation	Framework	Design/ Method	Sample/ Setting	Variables Studied and Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Santos et al. (2014)	Jean Watson's Theory of Human Caring	Descriptive qualitative approach	12 pediatric nurses in a pediatric hospital.	Child, hospitalized, nursing care, nursing theory, professional-family relations, family nursing, models, nursing.	Semi structured interview with 12 pediatric nurses in a pediatric hospital.	Three Stages: 1. Presentation of theoretical content 2. Engagement of families in the light of Watson's theory 3. Interview of 12 pediatric nurses The interviews were analyzed using inductive thematic analysis, being possible to form three themes: 1. Recognizing a framework for care: 2. Considering the institutional context 3. Challenges in family relationships	The theory favored reflections about self, about the institution and about nurses' relationship with the family of the child normalized by a consciousness toward caring attitudes.	**Strengths**: Nurses revealed a clear awareness of the importance of improving relations and having a basis of theoretical frameworks for nursing, recognizing the relevance of incorporating elements from Jean Watson's theory in their practice with families. **Limitations**: The team lacked awareness and framework to care for the families and perceived themselves far from the moral ideal that brought them to the profession. **Critical Appraisal Tool & Rating**: JHNEB: III, A

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Schlagel & Jenko (2015)	Jean Watson's Theory of Human Caring	Predictive non-experimental	A small royal hospital in central Florida. Studied work over the span of 20 years on the integration of Jean Watson's caring theory throughout the hospital.	Nurse leadership, caring science theory integration and sustainability.	Interview of staff and reflection of a 20-year journey of a CNS who was recognized for her leadership that ultimately transformed and sustained a caring culture in a royal hospital.	CNS sphere of influence on patients, nursing practice, and organization/ system sphere.	1. Clinical leaders must be intentional in creating and preserving caring in a healthcare setting. Administrative/ leadership support is imperative in order to sustain a caring conscious organization. 2. Embedding Watson's caring theory into the institutions structure and processes of care resulted in improved quality and financial outcomes that transformed the culture of an entire organization.	**Strengths**: The Board of Trustees along with executive leadership recognized the impact of the work that the leadership of a CNS had on an entire organization and was later promoted to the CNE. **Limitations**: Work was done over a span of 20 years, no concrete data provided, or research done. **Critical Appraisal Tool & Rating**: JHNEB: III, A

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Suliman & Welman (2009)	Jean Watson's Theory of Human Caring	Questionnaire survey	A probability sample of 393 patients was drawn from three hospitals in three different regions of Saudi Arabia.	Difference between the perceived importance of caring behaviors and how frequently those caring behaviors were attended to by staff nurses.	The Caring Behaviors Assessment instrument was used in data collection.	Descriptive analysis included frequencies, percentages, and mean scores for caring behavior items and subscales.	Patients rated overall caring behaviors as important (97.2%) and frequently experienced (73.7%). The discrepancy between the importance of and frequency of attendance to caring behaviors by nurses was statistically significant ($t = -4.689$, $p = .001$).	**Strengths**: **Limitations**: Length of assessment tool and the potential burden on patients. **Critical Appraisal Tool & Rating**: JHNEB: III, A

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Taylor et al. (2008)	N/A	Prospective cohort	228 inpatients admitted to a medical ward of a Boston teaching hospital. Mean age 63, 37% male, 21% non - white, and 5% non-English speaking.	Adverse events, close calls, low-risk errors, and quality deficiencies.	Patient interview during and after their admission to assess problems encountered to admission.	Patient interviews, medical reviews.	The presence of any service quality deficiency more than doubled the odds of any adverse events, close call, or low-risk error were associated with the occurrence of adverse events and medical errors.	**Strengths**: Relationship that between patient-reported service quality and patient safety outcomes. **Limitations**: Small sample size and single site, potentially reducing its generalizability. **Critical Appraisal Tool & Rating**: JHNEB: III, A

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Variables Studied and Their Definitions	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice
Tonges & Ray (2011)	Swanson Caring Theory	Carolina Care Model	University of North Carolina Hospitals.	Pre and post results after the implementa-tion of the Carolina Care Model on patient satisfaction and nosocomial ulcers.	Patient satisfaction scores comparison between 2004 and 2010, Carolina Care and prevalence of nosocomial ulcers 2004 to 2010.	Mean score of patient satisfaction, prevalence of nosocomial ulcers.	Substantive improvements in patient satisfaction occurred after creation of the Carolina Care Model. There was an increase in over satisfaction from 83.7 (2008) to 86.1 (2010), nursing satisfaction from 88.7 to 89.6, the highest in pain control 85.4 to 87.8, and responsiveness improved 86 to 87.6 linear mean Nosocomial decubiti decreased by 50%.	**Strengths**: Health system successfully saw results after incorporating a caring theory in theory system. **Limitations**: Results took place over a long period of time; many factors could have influenced the results. **Critical Appraisal Tool & Rating**: JHNEB: III A

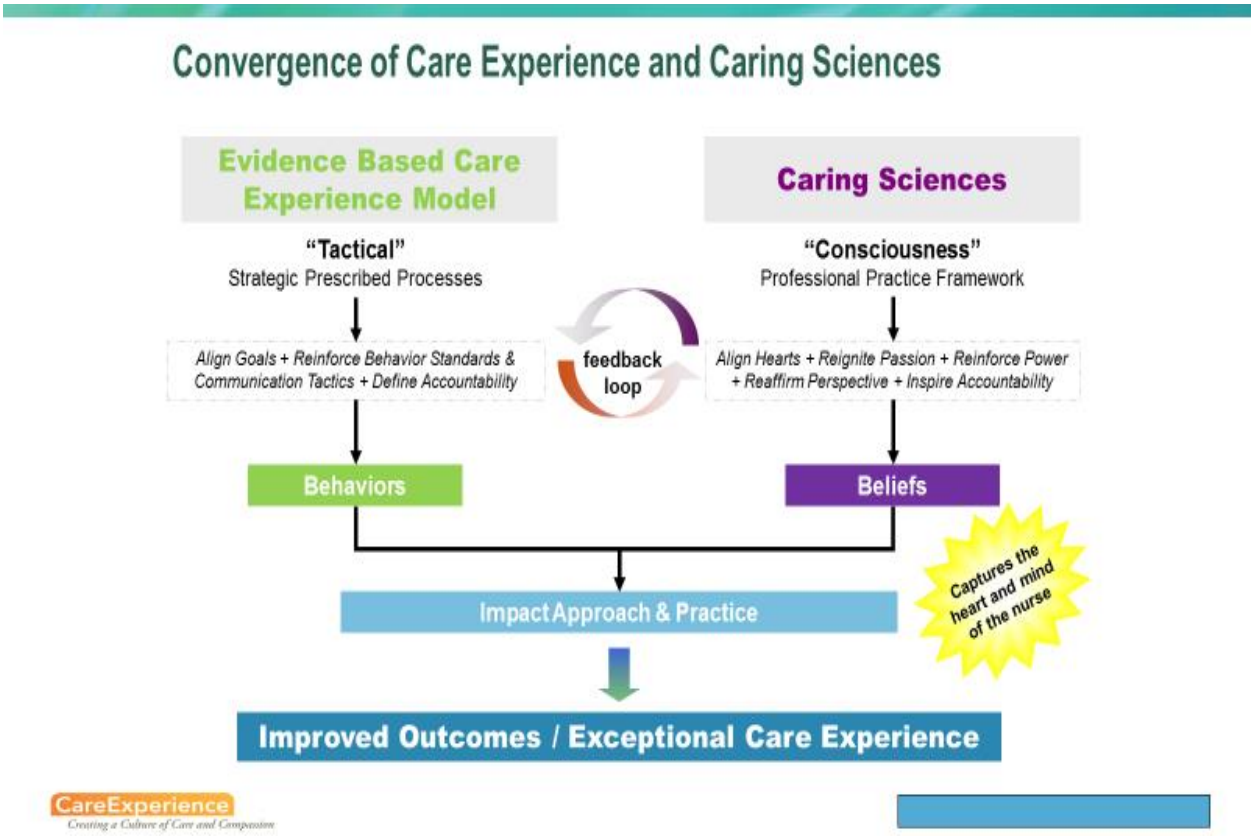
Appendix B

Ten Caritas Processes

1. Practicing loving kindness and equanimity for self and others
2. Being authentically present
3. Cultivating one's own spiritual practices
4. Develop and sustaining a helping-trusting authentic, caring relationship
5. Being present to and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for
6. Creative use of self and all ways of knowing/being/doing as part of the caring process
7. Engage in genuine teaching-learning experiences within context of caring relationship
8. Creating a healing environment at all levels
9. Reverentially and respectfully assisting with basic needs
10. Opening and attending to spiritual, mysterious, unknow existential dimensions of life-death-suffering (Watson, 2008)

Appendix C

Convergence of Care Experience and Caring Science



Appendix D

Responsibility/Communication Matrix

Stakeholder	Objective of Communication	Medium	Frequency	Audience	Responsible Owner
Plan shared with executive	Review HCAHPS score, project objective, and share concept. Get approval.	One to one	Once	Chief nursing officer/chief operating officer	Care experience leader
Plan shared with patient care nurse leaders	Review HCAHPS scores, project objective, and share concept. Initiate engagement and nurture relationships.	Nurse leader meetings	Once	Assistant nurse managers, managers, and director	Care experience leader
Plan shared with all hospital leaders	Review HCAHPS scores, project objective, and share concept. Introduce to caring science and their role in care experience.	Manager meeting	Once	Managers on the hospital side and the physician group	Care experience leader
Training with patient care services	Share HCAHPS scores, introduce Jean Watson's human caring theory, review care experience best practices, inspire. and get engagement and commitment.	Classroom	30 classes over four weeks	Registered nurses, patient care technicians, unit assistants, and respiratory therapists	Care experience leader
Training with nurse leaders	Share HCAHPS scores, introduce Jean Watson's human caring theory, review care experience best practices, inspire, and get engagement.	Classroom	Three classes over 6 weeks	Assistant nurse managers, managers, and director	Care experience leader
Training with regional care experience leader	Introduce Jean Watson's human caring theory, review connection to care experience best practices, discuss operationalizing.	Regional meeting	Monthly	Care experience leaders	Care experience leader

Appendix E

Gap Analysis

Current State	Gap	Desired State
1. Stakeholders lack of knowledge of Jean Watson's human caring theory 2. Patient Care Leaders in their position less than three years and/or new to healthcare system 3. No Care Experience Leader for over 7 years 4. Stakeholders did not understand the data 5. Stakeholders lack of understanding around their role and responsibility around care experience 6. Lack of understanding care experience best practices 7. Lack of understanding of the financial and reputation impact	1. Training to be done at various levels and content depending on the job responsibility 2. Training, coaching and mentoring of leaders 3. Show value in having a care experience to continue the work and prevent the decreased HCAHP scores in the future. 4. Training will need to be done on how to analyze the HCAHPS data 5. Provide employee with current and updated job description and review their roles and responsibilities around improving and sustain HCAHPS 6. Training on care experience best practices at all levels, validation and accountability initiatives in place 7. During the training this will be reviewed, HCAHPS will be displayed for all to see progress and comparison shared	1. Stakeholders will understand core concepts of Jean Watson's human caring theory 2. Seasoned Patient Care Leader that will have the ability to connect caring theory and care experience best practices 3. Facility will have full-time Care Experience Leader to sustain best practices 4. Stakeholders will know how to read and analyze the HCAHPS data and have practices in place to mitigate the decrease in HCAHPS scores 5. Stakeholders engaged and understand their role and responsibility around ensuring that evidence best practices are hard wired coupled with core concepts of caring theory 6. Care experience best practices would be hardwired and part of the culture 7. Stakeholders would understand the impact on the financial and reputation of the organization

Appendix F

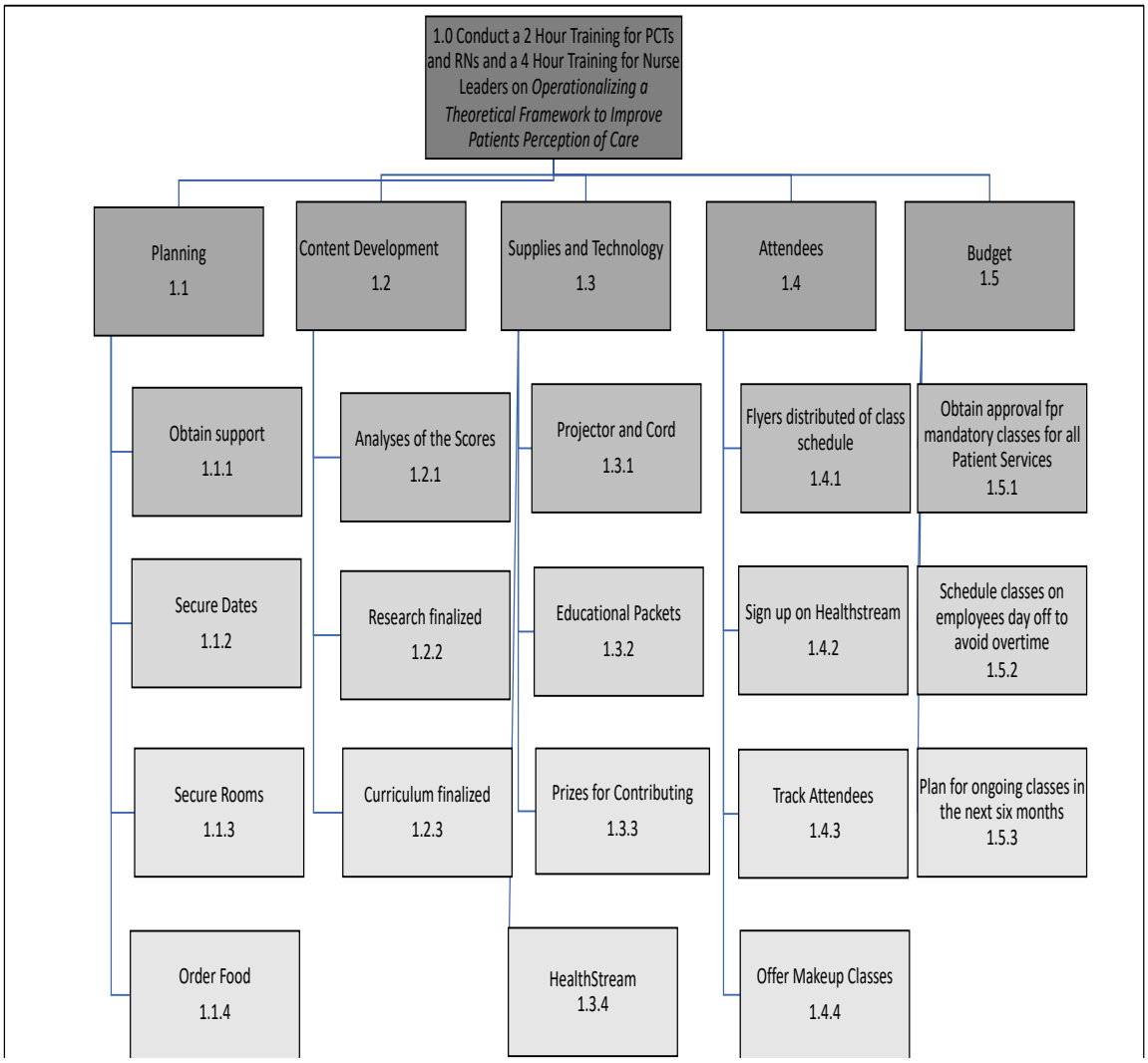
GANTT Chart

Year Action Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Assess HCAHP scores and organizational goals						
Build Relationship with Patient Care Services Leadership						
Assess knowledge of Jean Watson's Nursing Theory						
Assess knowledge of care experience best practices						
Validate care experience best practices with patient care services						
Validate care experience best practices with nurse leaders						
Create CORE Care Experience Committee that involves stakeholders						
Set up CORE Committee monthly meetings						
Weekly Email to CORE Team on HCAHP Scores						
Create an educational plan that incorporates care experience best practices with Jean Watson's caring theory for Patient Care Services						
Share plan with executive team						
Share plan with managers						
Share plan with physician group and partners						
Schedule and reserve room for training						
Promote and publicize mandatory classes						
Work with Education department to create HealthStream sign up						
Provide mandatory two-hour training for all Patient Care Services employees						
Create an educational plan that incorporates care experience best practices with Jean Watson's caring theory for Nurse Leaders						
Hospital Wide No Pass Zone Training						
Meet with 1:1 leaders of the ancillary departments (Environmental Services, Patient Care Coordinators, Admissions Office, Emergency Room, Peri Op, Patient Advisors that impact HCAHPS						
Create a monthly educational plan for region Care Experience Leaders						
My Medication Matters						
Share huddle messages to enculturate Jean Watson's Theory						
Attend monthly Caritas Committee						

Create an educational plan that incorporates care experience best practices with Jean Watson's theory for Patient Care Coordinators						
Mandatory Patient Care Coordinators 2-hour training						
Hospital Wide AIDET Training						
Ambassador Training						
Commit to Sit Campaign						
Hospital Wide AHEART Training						

Appendix G

Work Breakdown Structure



Appendix: H

SWOT Analysis

Strengths	Weaknesses
Very caring nurses Engaged and caring nurse educators Nurse leaders wanted to do a good job CEL previous CNE Autonomy for CEL	All new inexperienced nurse leaders No real understanding of HCAHPS, EBP, Caring Science, their role Not a priority for leaders in general No sense of urgency or engagement Industrialized looking hospital Small rooms Baseline SS 2.9 CEL role without direct authority Lack of engagement of staff PCS with huge knowledge gap of theories
Opportunities	**Threats**
Disseminate work that could improve HCAHPS in other regional hospitals Strengthen possibilities for adoption and spread of CS programs Improve overall care of patients and promote healing	Turnover Sustainability Outside competing priorities Level of understanding of human caring theory and ability to teach others that will impact practice

Appendix I

Budget

				Total Dollars
Training Material (paper, ink, staples)				45
	Number of Empolyees	**Average Hourly Rate**	**Class Hours**	**Total Dollars**
Inpatient Nurse	188	$90	2	33,840.00
Patient Care Technicians	10	$25	2	500
Nurse Leader	15	$84	8	10,080
Total Dollars per Year				44,465.00

Appendix J

HCAHPS Survey Questions

During this hospital stay...

- how often did nurses treat you with courtesy and respect? (Q1)
- how often did nurses listen carefully to you? (Q2)
- how often did nurses explain things in a way you could understand? (Q3)

During this hospital stay...

- how often did doctors treat you with courtesy and respect? (Q5)
- how often did doctors listen carefully to you? (Q6)
- how often did doctors explain things in a way you could understand? (Q7)

During this hospital stay…

- after you pressed the call button, how often did you get help as soon as you wanted it? (Q4)
- how often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? (Q11)

During this hospital stay...

- how often was your pain well controlled? (Q13)
- how often did the hospital staff do everything they could to help you with your pain?

Before giving you any new medicine...

- how often did hospital staff tell you what the medicine was for? (Q16)
- how often did hospital staff describe possible side effects in a way you could understand? (Q17)

During this hospital stay...

- how often were your room and bathroom kept clean? (Q8)

During this hospital stay…

- how often was the area around your room quiet at night? (Q9)

During this hospital stay...

- did hospital staff talk with you about whether you would have the help you needed when you left the hospital? (Q19)
- did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Q20)
- Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? (Q21)
- Would you recommend this hospital to your friends and family? (Q22) (Centers for Medicare & Medicaid Services, 2017)

Appendix K

Data Analysis Tool

CARE EXPERIENCE - STAR Rating	Baseline	Oct	Nov	Dec	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	PYTD	Imp. from Baseline	↑ Star	↓ Star	Gap to ↑ Star	Gap to ↓ Star
HCAHPS: Overall Hospital Rating																			
HCAHPS: Recommend Hospital																			
HCAHPS: RN Comm.																			
RN Comm: Courtesy and Respect																			
RN Comm: Listen Carefully to You																			
RN Comm: Explain Things																			
HCAHPS: MD Comm.																			
MD Comm: Courtesy and Respect																			
MD Comm: Listen Carefully to You																			
MD Comm: Explain Things																			
HCAHPS: Cleanliness																			
HCAHPS: Quiet																			
HCAHPS: Staff Responsiveness																			
Get Help as Soon as You Wanted																			
Get Help in Getting to the Bathroom																			
HCAHPS: Pain Management																			
Pain Well Controlled																			
Did Everything to Help Your Pain																			
HCAHPS: Comm. about Med																			
Staff Told What Medicine Was For																			
Staff Described Possible Side Effects																			
HCAHPS: Discharge Info.																			
Talked About Help You Would Need																			
Received Info Regarding Symptoms																			
HCAHPS: Care Transitions																			
My Preferences Taken Into Account																			
Understanding In Managing My Health																			
Clearly Understood My Medications																			

CARE EXPERIENCE - Summary Star	Baseline													PYTD	Imp. from Baseline	Gap to ↑ Star	Gap to ↓ Star	Performance Period
HCAHPS: Summary Star																		
HCAHPS: Summary Star - No Pain Mngmt																		

	5 Star
	4 Star
	3 Star
	2 Star
	1 Star

Appendix L

Non-Research Determination

DNP Statement of Non-Research Determination Form

Student Name: Deb Morton

Title of Project:

Operationalizing a Theoretical Framework of Caring and its Impact on Patients Perception

Brief Description of Project:

A large integrated healthcare system in Northern California is seeing a decrease in their Hospital Assessment of Healthcare Providers (HACHPS) and System Summary star. Despite massive investments in patient experience initiatives in recent years, the consumer satisfaction index for hospitals has risen just 0.3% per year on average. New approaches must be explored. Coupling care experience best practices with a theoretical framework of caring is the new approach needed.

Practicing nurses are not always aware of the benefits of a caring theory and therefore the caring practices are not always existent in many hospitals (Tonges & Ray, 2011). Santos et al. (2014) found that connecting nursing best practices with a caring theory improves patient outcomes such as care experience and quality metrics. Incorporating a caring theory with care experience best practices will move the nursing theory from a conceptual level to an operational level.

A) Aim Statement:

Develop, implement and evaluate a playbook for care experience leaders that will guide them to connect care experience best practices (CEBP) with caring science (CS) and improve overall summary star on the HCAHPS.

The primary aim of this project is to operationalize a caring theory with frontline registered nurses (RN), and patient care service (PCS) leaders to improve the patients experience, quality and safety in a healthcare setting. This will be accomplished by coupling best practices with the core concepts of Jean Watson's nursing theory.

B) Description of Intervention:

Create a playbook that will incorporate (CEBP) with the core concepts Jean Watson's caring theory. CEBP include: hourly rounds, bedside report, nurse leader rounds, direct report rounds, service recovery, and the five fundamentals of patient communication. Jean Watson's caring theory include: Transpersonal caring relationships, caring moments and, Ten Caritas Processes.

Some thoughts for the playbook title:

1. How to Improve Clinical Outcomes through Caring Clinicians and Clinical Practices
2. Practice + Purpose = Positive Patient Perception (s)
3. "Thank You for Making it Okay to Care Again": a playbook on how to connect purpose to practice

(After training this week one of the nurses stated, "I want to thank you for making it okay to care again," the rest of the class agreed. I thought this was a very powerful statement and validated the importance of this project. I thought that could be my introduction into the playbook with

some literature supporting the disconnect between purpose and practice, burn out in nursing, turnover rate in nursing.)

C) How will this intervention change practice?

Jean Watson's caring theory is the caring theory for a large Northern California healthcare system, however as evidence of an overall regional decrease in the HCAHPS scores there is an obvious disconnect between theory and practice. It is believed that incorporating a caring theory with care experience best practices will move the nursing theory from a conceptual level to an operational level. The question to be explored is: In acute care, RNs and PCS leaders (P) what is the effect of coupling best practices with a caring theory (I) compared to no caring theory (C) on the overall summary star HCAHP score (O) within six months of implementation (T)?

Phase 1: The intent is to reconnect purpose, (caring science) with practice (care experience best practices) among patient care service employees. This will include training all frontline nurses on the benefits of incorporating Jean Watson's Caring Theory (NCAL caring theory), and care experience best practices and that impact it will make on patient's perception of care.

Phase 2: Bring joy back to the bedside through creating interpersonal caring relationships, sharing caring moments and Then Caritas Processes, ultimately create a caring culture in a hospital setting. When we sustain another human being, we sustain ourselves (Jean Watson, 2008).

D) Outcome measurements:

- Improve HCAHPS summary star overall rating from baseline of 2.9 to goal of 3.2 in six months after implementation of playbook.
- The ratio of positive comment to negative comments will be higher on the HCAHPS survey after implementation of playbook, compared to pre-implementation of playbook within six months.
- Patient's perception of being cared for will be assessed pre-intervention and post-intervention by reviewing the organizations customized Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) question: "Nurses treated me with loving kindness". An increase by at least 0.5 in summary star will be noted within in six months after implementation of playbook.
- A nurse survey will be done to assesses if the nurse feels like she is practicing in a more caring way since the training, *Operationalizing a Theoretical Framework of Caring*. Survey results will show that at least 50% of the nurses who attended the training will admit that they are practicing in a more caring way then pre-training.

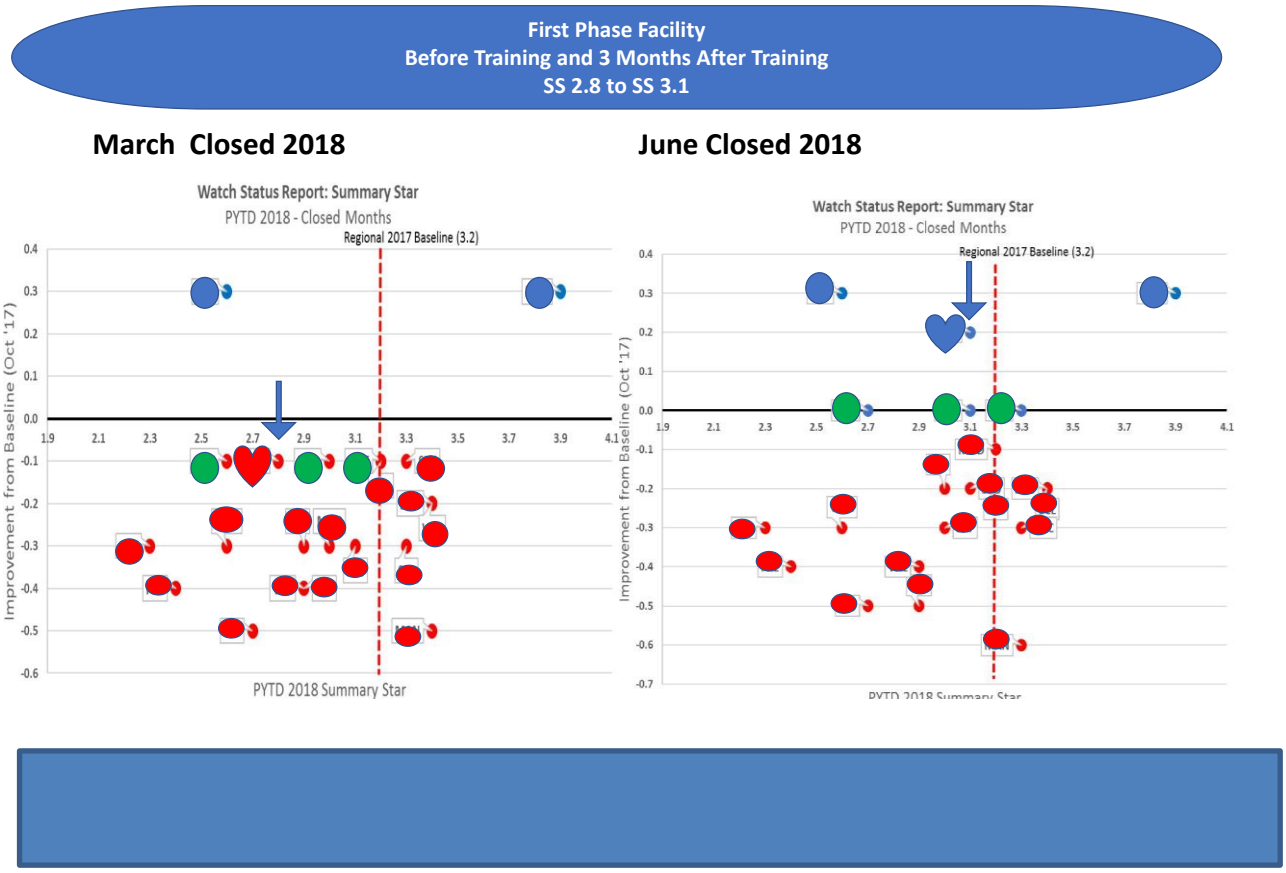
To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

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

Appendix M

First Phase: Watch Status Report Pre-Training and Three Months Post-Training

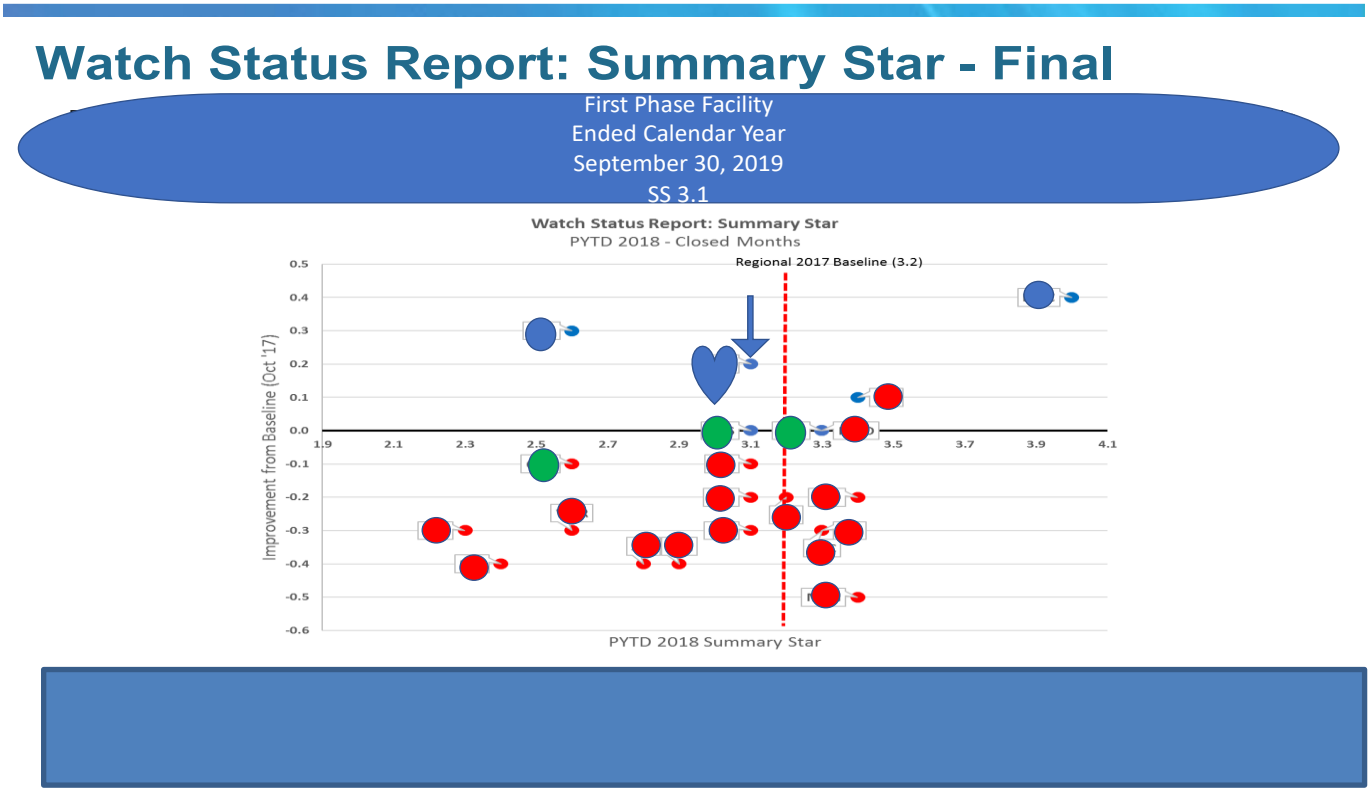
SS 2.8 March Pre-Training and SS 3.1, June Three Post-Training



Appendix N

First Phase: Watch Status Report Final

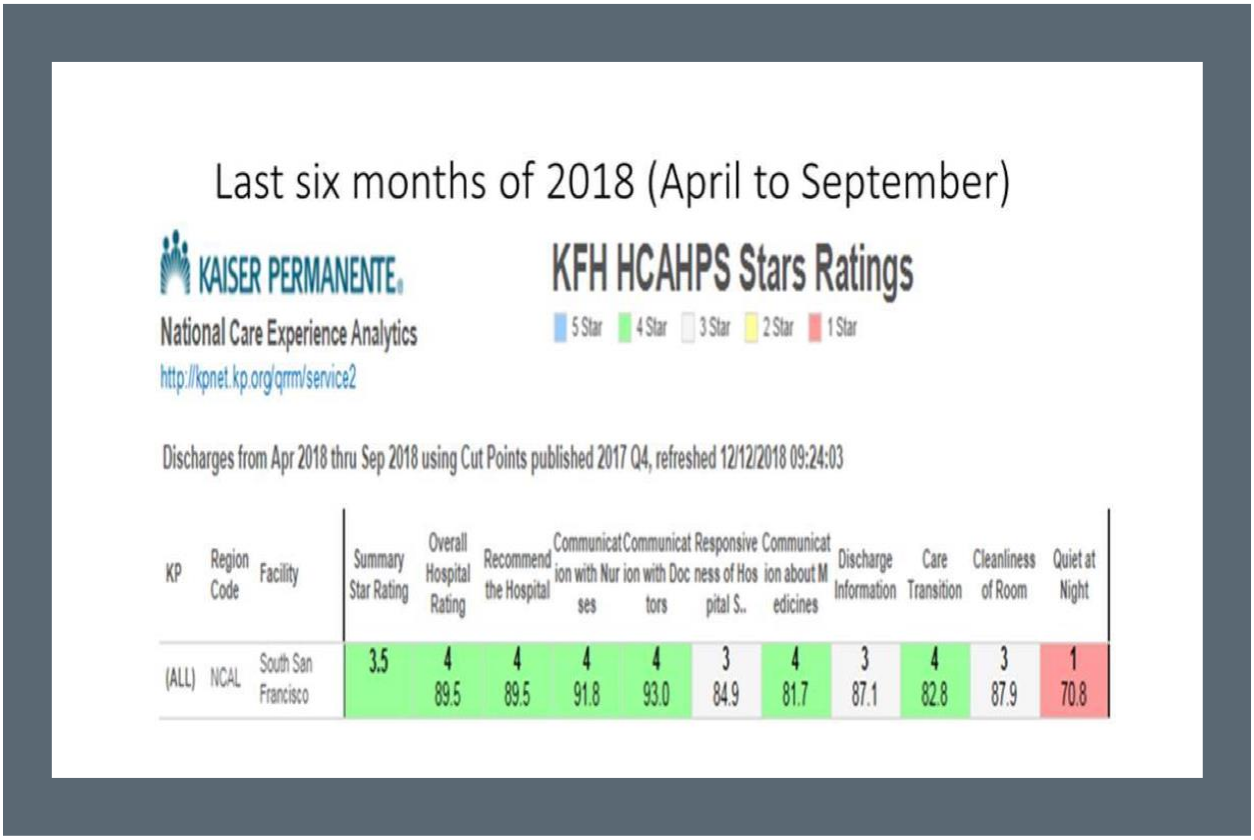
SS 3.1 September, Six Month Post-Training



Appendix O

April to September, Excluding Pre-Training Scores

April to September 2018 SS 3.5, Excluding Pre-Training Scores



Last six months of 2018 (April to September)

KAISER PERMANENTE

National Care Experience Analytics

http://kpnet.kp.org/qrm/service2

KFH HCAHPS Stars Ratings

5 Star 4 Star 3 Star 2 Star 1 Star

Discharges from Apr 2018 thru Sep 2018 using Cut Points published 2017 Q4, refreshed 12/12/2018 09:24:03

KP	Region Code	Facility	Summary Star Rating	Overall Hospital Rating	Recommend the Hospital	Communication with Nurses	Communication with Doctors	Responsiveness of Hospital S..	Communication about Medicines	Discharge Information	Care Transition	Cleanliness of Room	Quiet at Night
(ALL)	NCAL	South San Francisco	3.5	4 89.5	4 89.5	4 91.8	4 93.0	3 84.9	4 81.7	3 87.1	4 82.8	3 87.9	1 70.8

Appendix P

First Pilot: Open Data August 2019

SS 3.1 Open Data, August 2019

First Pilot Facility
15 months post training
Summary Star of 3.1 Open Data

Service Line	All IP Combined
Facility	South San Francisco
Unit	All_Units
Open Data	Yes
Target Trigger	No
Data As Of	9/4/19

CARE EXPERIENCE - Summary Star	Oct-18 Close	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19 Close	Mar-19 Close	Apr-19 Close	May-19 Close	Jun-19 Open	Jul-19 Open	Aug-19 Open	Sep-19 Open	2019 PYTD	Gap to ↑ Star	Gap to ↓ Star	Performance Period	Imp. from Baseline
HCAHPS: Summary Star	3.3	2.6	2.8	3.4	3.3	2.4	2.9	2.4	2.9	2.9	1.5		3.1	0.9	1.1	Oct'18 - Sep'19	0.1

Appendix Q

6 South Summary Star and Linear Mean Closed Data

CARE EXPERIENCE - STAR Rating	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019 PYTD	Imp. from Baseline	↑ Star	↓ Star	Gap to ↑ Star	Gap to ↓ Star
HCAHPS: Overall Hospital Rating	3	3	5	4	5									4	1.0	5	3	1.6	2.4
HCAHPS: Recommend Hospital	3	4	5	4	5									4	1.0	5	3	0.9	4.1
HCAHPS: RN Comm.	2	2	3	2	3									3	1.0	4	2	3.2	0.8
RN Comm: Courtesy and Respect	3	3	4	3	5									4	1.0	5	3	2.3	0.7
RN Comm: Listen Carefully to You	1	3	3	2	2									2	1.0	3	1	1.0	3.0
RN Comm: Explain Things	1	2	3	1	2									2	1.0	3	1	2.2	1.8
HCAHPS: MD Comm.	3	3	5	3	4									3	0.0	4	2	1.0	3.0
MD Comm: Courtesy and Respect	3	4	5	4	5									5	2.0		4		1.3
MD Comm: Listen Carefully to You	3	1	4	2	4									3	0.0	4	2	2.6	1.4
MD Comm: Explain Things	2	3	4	2	3									3	1.0	4	2	2.7	1.3
HCAHPS: Cleanliness	2	2	4	1	2									2	0.0	3	1	3.0	2.0
HCAHPS: Quiet	1	2	1	1	2									1	0.0	2		4.3	
HCAHPS: Staff Responsiveness	3	2	5	2	5									3	0.0	4	2	1.7	3.3
Get Help as Soon as You Wanted	3	3	3	3	5									3	0.0	4	2	0.8	4.2
Get Help in Getting to the Bathroom	3	1	5	1	4									3	0.0	4	2	2.7	2.3
Pain Well Controlled																			
Did Everything to Help Your Pain																			
HCAHPS: Comm. about Med	2	5	4	1	3									3	1.0	4	2	1.7	3.3
Staff Told What Medicine Was For	5	5	5	3	5									5	0.0		4		3.5
Staff Described Possible Side Effects	1	5	1	1	1									1	0.0	2		1.8	
HCAHPS: Discharge Info.	3	3	5	3	3									4	1.0	5	3	1.4	1.6
Talked About Help You Would Need	3	5	5	1	4									5	2.0		4		0.5
Received Info Regarding Symptoms	3	2	5	5	3									4	1.0	5	3	2.3	0.7
HCAHPS: Care Transitions	3	4	5	2	3									4	1.0	5	3	3.2	1.8
My Preferences Taken Into Account	2	4	5	1	4									3	1.0	4	2	0.5	3.5
Understanding In Managing My Health	2	4	5	2	3									4	2.0	5	3	3.7	1.3
Clearly Understood My Medications	4	5	5	3	3									4	0.0	5	3	1.4	3.6

CARE EXPERIENCE - Summary Star	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019 PYTD	Imp. from Baseline	Gap to ↑ Star	Gap to ↓ Star	Performance Period
HCAHPS: Summary Star - No Pain Mngmt	2.6	3.1	4.3	2.3	3.5									3.2	0.6	0.8	1.2	Oct'18 - Sep'19

CARE EXPERIENCE - N Size Percent Received	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Average N Size for PY2019	29	89%	92%	96%	65%								

5 Star
4 Star
3 Star
2 Star
1 Star

CARE EXPERIENCE - Linear Mean	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019 PYTD	Imp. from Baseline	2019 Target	2019 Stretch	Gap to Target	Gap to Stretch
HCAHPS: Overall Hospital Rating	86.0	89.2	93.7	90.0	93.2									91.4	5.4				
HCAHPS: Recommend Hospital	87.2	90.7	95.1	91.7	95.2									93.1	5.9				
HCAHPS: RN Comm.	87.6	89.3	92.3	87.9	89.9									89.8	2.3	90.9	92.4	-1.1	-2.5
RN Comm: Courtesy and Respect	90.1	91.0	93.6	91.7	95.2									92.7	2.7				
RN Comm: Listen Carefully to You	86.3	89.7	91.0	87.7	87.3									89.0	2.7				
RN Comm: Explain Things	86.3	87.2	92.3	84.5	87.3									87.8	1.5				
HCAHPS: MD Comm.	90.5	90.2	94.8	90.1	93.6									92.0	1.5				
MD Comm: Courtesy and Respect	92.3	93.6	97.4	94.0	96.7									95.3	3.1				
MD Comm: Listen Carefully to You	90.8	85.9	93.6	89.3	93.7									90.4	-0.3				
MD Comm: Explain Things	88.6	91.0	93.3	86.9	90.5									90.3	1.8				
HCAHPS: Cleanliness	84.0	84.6	91.4	77.4	82.5									84.0	0.0	85.1	86.5	-1.1	-2.5
HCAHPS: Quiet	69.8	77.3	71.6	65.4	77.8									72.7	2.8	75.3	76.8	-2.6	-4.1
HCAHPS: Staff Responsiveness	84.1	80.5	91.0	80.1	91.5									85.3	1.2	86.7	87.6	-1.4	-2.3
Get Help as Soon as You Wanted	83.7	84.1	84.8	84.0	94.1									86.2	2.5				
Get Help in Getting to the Bathroom	84.5	76.9	97.2	76.2	88.9									84.3	-0.1				
Pain Well Controlled	87.6																		
Did Everything to Help Your Pain	90.2																		
HCAHPS: Comm. about Med	76.0	92.8	80.6	71.1	77.8									79.3	3.3	79.2	80.5	0.1	-1.1
Staff Told What Medicine Was For	86.4	96.7	92.6	80.0	86.7									88.5	2.1				
Staff Described Possible Side Effects	65.6	88.9	68.5	62.2	68.9									70.2	4.6				
HCAHPS: Discharge Info.	86.7	88.4	94.2	87.6	87.5									89.6	2.9	87.4	88.6	2.2	1.0
Talked About Help You Would Need	85.4	96.0	96.2	79.2	90.0									90.5	5.1				
Received Info Regarding Symptoms	87.9	80.8	92.3	96.0	85.0									88.7	0.8				
HCAHPS: Care Transitions	80.4	85.5	89.4	78.1	81.9									83.8	3.4	82.6	83.4	1.2	0.4
My Preferences Taken Into Account	76.8	82.6	87.7	75.6	84.2									82.5	5.7				
Understanding In Managing My Health	79.1	84.6	89.7	78.6	80.0									83.3	4.3				
Clearly Understood My Medications	85.3	89.4	90.7	80.0	81.5									85.6	0.3				

Above Baseline
At Baseline
Below Baseline

Appendix R

7 South Summary Star and Linear Mean Closed Data

CARE EXPERIENCE - STAR Rating	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019 PYTD	Imp. from Baseline	↑ Star	↓ Star	Gap to ↑ Star	Gap to ↓ Star
HCAHPS: Overall Hospital Rating	3	5	4	5	4									5	2.0		4		1.3
HCAHPS: Recommend Hospital	4	5	4	4	3									4	0.0	5	3	2.3	2.7
HCAHPS: RN Comm.	3	5	3	5	3									4	1.0	5	3	1.4	1.6
RN Comm: Courtesy and Respect	3	5	4	5	4									5	2.0		4		2.7
RN Comm: Listen Carefully to You	2	5	2	5	5									4	2.0	5	3	0.8	2.2
RN Comm: Explain Things	2	5	1	5	1									3	1.0	4	2	3.0	1.0
HCAHPS: MD Comm.	4	5	3	4	4									4	0.0	5	3	0.6	2.4
MD Comm: Courtesy and Respect	4	5	4	3	5									5	1.0		4		1.8
MD Comm: Listen Carefully to You	3	5	4	5	4									5	2.0		4		1.7
MD Comm: Explain Things	3	5	1	5	2									3	0.0	4	2	1.3	2.7
HCAHPS: Cleanliness	2	3	1	5	4									3	1.0	4	2	1.3	3.7
HCAHPS: Quiet	2	1	4	3	2									3	1.0	4	2	3.8	1.2
HCAHPS: Staff Responsiveness	3	5	4	5	4									4	1.0	5	3	1.0	4.0
Get Help as Soon as You Wanted	2	4	5	5	4									5	3.0		4		1.2
Get Help in Getting to the Bathroom	3	5	2	5	5									4	1.0	5	3	2.1	2.9
Pain Well Controlled																			
Did Everything to Help Your Pain																			
HCAHPS: Comm. about Med	1	5	1	5	5									4	3.0	5	3	0.6	5.4
Staff Told What Medicine Was For	4	5	4	5	5									5	1.0		4		3.3
Staff Described Possible Side Effects	1	5	1	5	5									4	3.0	5	3	3.5	2.5
HCAHPS: Discharge Info.	3	3	1	5	1									1	-2.0	2		1.8	
Talked About Help You Would Need	4	3	1	5	5									3	-1.0	4	2	2.9	2.1
Received Info Regarding Symptoms	2	3	1	3	1									1	-1.0	2		8.8	
HCAHPS: Care Transitions	3	4	4	5	2									4	1.0	5	3	3.5	1.5
My Preferences Taken Into Account	2	3	4	4	1									3	1.0	4	2	1.4	2.6
Understanding In Managing My Health	3	5	4	4	1									4	1.0	5	3	4.5	0.5
Clearly Understood My Medications	3	4	4	5	5									4	1.0	5	3	0.5	4.5

CARE EXPERIENCE - Summary Star	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019 PYTD	Imp. from Baseline	Gap to ↑ Star	Gap to ↓ Star	Performance Period
HCAHPS: Summary Star - No Pain Mngmt	2.8	4.3	2.8	4.7	3.2									3.6	0.8	0.4	1.6	Oct'18 - Sep'19

CARE EXPERIENCE - N Size Percent Received	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Average N Size for PY2019	10	102%	122%	71%	112%								

5 Star
4 Star
3 Star
2 Star
1 Star

CARE EXPERIENCE - Linear Mean	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2019 PYTD	Imp. from Baseline	2019 Target	2019 Stretch	Gap to Target	Gap to Stretch
HCAHPS: Overall Hospital Rating	89.3	97.0	91.7	92.9	91.8									93.3	3.9				
HCAHPS: Recommend Hospital	91.1	96.7	91.7	90.5	87.9									91.7	0.6				
HCAHPS: RN Comm.	89.5	97.8	89.8	96.8	91.9									93.6	4.1	90.9	92.4	2.7	1.3
RN Comm: Courtesy and Respect	91.6	100.0	94.4	100.0	93.9									96.7	5.1				
RN Comm: Listen Carefully to You	89.2	96.7	88.9	95.2	97.0									94.2	5.0				
RN Comm: Explain Things	87.8	96.7	86.1	95.2	84.8									90.0	2.2				
HCAHPS: MD Comm.	92.6	100.0	91.5	93.7	92.9									94.4	1.8				
MD Comm: Courtesy and Respect	94.2	100.0	94.4	90.5	97.0									95.8	1.6				
MD Comm: Listen Carefully to You	92.2	100.0	93.9	95.2	93.9									95.7	3.5				
MD Comm: Explain Things	91.5	100.0	86.1	95.2	87.9									91.7	0.2				
HCAHPS: Cleanliness	83.3	90.0	81.8	100.0	90.9									89.7	6.4	85.1	86.5	4.7	3.2
HCAHPS: Quiet	78.5	73.3	88.9	81.0	80.0									81.2	2.7	75.3	76.8	5.9	4.4
HCAHPS: Staff Responsiveness	82.5	91.7	88.3	93.3	89.6									90.0	7.5	86.7	87.6	3.3	2.4
Get Help as Soon as You Wanted	82.2	88.9	96.7	93.3	86.7									91.2	9.0				
Get Help in Getting to the Bathroom	82.9	94.4	80.0	93.3	92.6									88.9	6.0				
Pain Well Controlled	75.0																		
Did Everything to Help Your Pain	86.1																		
HCAHPS: Comm. about Med	69.4	94.4	70.2	94.4	94.4									85.4	16.0	79.2	80.5	6.2	4.9
Staff Told What Medicine Was For	80.6	94.4	83.3	88.9	88.9									88.3	7.7				
Staff Described Possible Side Effects	58.1	94.4	57.1	100.0	100.0									82.5	24.3				
HCAHPS: Discharge Info.	85.5	87.5	70.0	92.9	72.7									79.2	-6.3	87.4	88.6	-8.3	-9.4
Talked About Help You Would Need	88.9	87.5	70.0	100.0	90.9									86.1	-2.8				
Received Info Regarding Symptoms	82.1	87.5	70.0	85.7	54.5									72.2	-9.9				
HCAHPS: Care Transitions	79.9	83.8	85.7	88.6	77.6									83.5	3.6	82.6	83.4	1.0	0.1
My Preferences Taken Into Account	77.4	81.5	86.1	85.7	73.3									81.6	4.2				
Understanding In Managing My Health	80.0	86.7	86.1	85.7	72.7									82.5	2.5				
Clearly Understood My Medications	82.4	83.3	84.8	94.4	86.7									86.5	4.1				

Above Baseline

At Baseline

Below Baseline

Appendix S

6 South and 7 Center Final Data

6 South

Service Line	All IP Combined
Facility	San Francisco
Unit	6 South
Open Data	No
Target Trigger	No
Data As Of	9/11/2019

CARE EXPERIENCE - STAR Rating	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19 Close	Mar-19 Close	Apr-19 Close	May-19 Close	Jun-19 Close	Jul-19	Aug-19	Sep-19	2019 PYTD
HCAHPS: Overall Hospital Rating	3	3	5	4	5	3	4	3	2	3				3
HCAHPS: Recommend Hospital	3	4	5	4	5	3	4	3	3	3				4

7 Center

Service Line	All IP Combined
Facility	San Francisco
Unit	7 Center
Open Data	No
Target Trigger	No
Data As Of	9/11/2019

CARE EXPERIENCE - STAR Rating	Baseline	Oct-18	Nov-18 Close	Dec-18 Close	Jan-19 Close	Feb-19 Close	Mar-19 Close	Apr-19 Close	May-19 Close	Jun-19 Close	Jul-19	Aug-19	Sep-19	2019 PYTD
HCAHPS: Overall Hospital Rating	3	5	4	5	4	4	4	3	4	2				4
HCAHPS: Recommend Hospital	4	5	4	4	3	3	3	4	4	3				4

Appendix T

Letter of Support

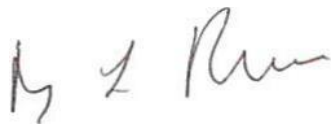
UNIVERSITY OF SAN FRANCISCO

ELDNP STUDENT

To Who it May Concern:

This letter is to support Debra J Morton RN, MLDR to implement her DNP Comprehensive Project at South San Francisco, Kaiser Permanente. We give Debra J. Morton permission to use the name of our agency in her DNP Comprehensive Project Paper and in future presentations and publications.

Sincerely,



Mary Linda Rivera
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