

This is My Story:

Using Patient Personalization Posters to Improve Nurses' Caring Behaviors

Kelly S. Johnson

Jacksonville University

Keigwin School of Nursing

Submitted in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice

Faculty Chair: Roberta Christopher, EdD, MSN, ARNP, NE-BC, CHTS-CP

Date Approved: April 30, 2019



## Table of Contents

List of Tables .....	6
List of Figures .....	7
Acknowledgments.....	8
Abstract.....	9
Background and Significance .....	10
Problem and Purpose .....	14
Project Site: A Planetree Organization.....	14
Patient Personalization Posters.....	15
Problem Statement .....	15
Purpose Statement.....	16
Literature Review.....	17
Purpose/Objectives of the Review .....	17
Literature Search Criteria and Strategies .....	18
Patient-connectedness.....	18
Dehumanization.....	21
Patient experience.....	23
Patient-centered care.....	24
Caring behaviors.....	26
Critical care nurses and caring behaviors.....	27
Empathy.....	29
Patient stories and narratives .....	30
Summary of the Literature .....	32
Definition of Key Terms .....	34
Theoretical Framework.....	35
Quality Improvement Framework: Appreciative Inquiry .....	37
Project Design and Implementation.....	40
Goal of the Project.....	40

THIS IS MY STORY	4
Setting.....	41
Population.....	42
Intervention & Implementation.....	43
Planning the Intervention .....	43
Project Plan .....	44
Implementation.....	44
Timeline .....	48
Evaluation & Data Analysis Plan .....	48
Evaluation Plan .....	48
Data Analysis Plan .....	50
Stakeholder Assessment.....	53
Organizational Analysis .....	53
Fiscal Considerations .....	54
Ethical Considerations.....	56
Project Outcomes .....	57
Statistical Analysis .....	57
Limitations .....	63
Recommendations for Future Projects .....	65
Implications for Practice .....	65
Dissemination Plans .....	67
Summary .....	68
References.....	70
Appendix A: Assessment of Readiness for Planetree Re-designation.....	83
Appendix B: Johns Hopkins Nursing Evidence Table .....	84
Appendix C: Sample Press Ganey Survey (HCAHPS) .....	85
Appendix D: Progressive Care Unit HCAHPS scores.....	89
Appendix E: Sample Poster .....	90

THIS IS MY STORY	5
Appendix F: Educational Flyer.....	91
Appendix G: Timeline .....	92
Appendix H: WCPS Tool .....	93
Appendix I: Data Collection Tool.....	94
Appendix J: Staff Education Evaluation Tool .....	95
Appendix K: Post-implementation Staff Evaluation Tool.....	96
Appendix L: SWOT Analysis.....	97
Appendix M: Written permission to use Watson Patient Caritas tool .....	98
Appendix N: Completed Poster Example .....	99
Appendix O: Descriptive Statistics of WCPS questionnaire .....	100
Appendix P: Staff Education Evaluation .....	103
Appendix Q: Post-implementation Staff Evaluation .....	104

List of Tables

Table 1: Cost Itemization..... 55

Table 2: Descriptive Statistics of Demographics..... 56

Table 3: Analysis of WCP Score; Overall Effects of Fixed Factors..... 59

Table 4: Analysis of WCPS score comparisons between SICU and MICU..... 59

Table 5: Pre/Post Intervention HCAHPS Scores ..... 60

List of Figures

Figure 1. Appreciative inquiry Model ..... 38

### Acknowledgments

I cannot begin to thank Dr. Roberta Christopher for all of her support and encouragement throughout this program. She has inspired me to be “joyful” and to follow my dream! I am also grateful to the Doctoral of Nursing Practice (DNP) committees and faculty for their continued support throughout the DNP program. I am fortunate to have been taught by some of the finest faculty members in the nation.

Most of all, to my caring, loving, and supportive husband, Matt: my sincerest gratitude. You were my constant reminder that I can do anything I set my mind to do. This adventure took us from coast to coast and you were always there cheering me on. You are my hero and I am thankful for all that you have done to make my dream possible!

### Abstract

The critical care environment renders patients unable to share the kind of personal information that illuminates their story outside of the intensive care unit. Therefore, learning about the individuality of this patient population and building caring relationships with them is more difficult than with a fully communicative patient.

The aim of this project was to investigate the relationship between the patients' and families' perceptions of caring behaviors and the use of the "This is My Story" poster for critically ill adults.

A two-group comparison was done between patients in a surgical intensive care unit who received the "This is My Story" posters and patients in a medical intensive care unit who did not receive the "This is My Story" posters, measuring nurses' caring behaviors with the Watson Caritas Patient Score©.

The implementation of the patient personalization poster in the SICU has significantly improved the patient rating of caring practices of critical care nurses. The Watson Caritas Patient Score© (WCPS) score in the SICU was improved by 47% compared to that of the medical intensive care unit MICU (no poster).

### This is My Story:

#### The Use of Patient Personalization Posters to Improve Caring Behaviors of Critical Care Nurses

Many patients in an intensive care unit are unable to communicate effectively because of their underlying diagnosis or resulting medical interventions. Because these patients are unable to share the kind of personal information that illuminates their story outside of the intensive care unit, learning about the individuality of this patient population and building caring relationships with them is more difficult than with a fully communicative patient. A quality improvement project called “This is My Story” is proposed as an adjunct to provide a way for critical care nurses to connect with their patients and improve caring behaviors as perceived by patients (and/or their families) in the intensive care unit.

### **Background and Significance**

Communication with patients and their families is an essential part of critical care nursing. Brown (2012) sees connection to others as a central truth of human life. Our relationships with patients and families during a critical illness is intimate, yet often is perceived as uncaring (Weyant, Clukey, Roberts, & Henderson, 2017). In attempting to meet the overwhelming physical demands of a critically ill patient, the nurse becomes highly task-focused and may view communication only as an impediment to getting things done. In this way, nurses, who may lack adequate resources, are challenged to provide comprehensive nursing care to patient populations whose health conditions have become increasingly complex over time (Amendolair, 2012). The incongruence between the amount of care that nurses want to provide and that which they are able to provide can lead to decreased job satisfaction and increased

turnover rates (Amendolair, 2012). The heightened challenges of working in the technological environment of the ICU—compounded by the amount of time required to document information in the electronic medical record (EMR) and the constant demands placed upon the nurse at the bedside—produce exorbitant levels of stress for the ICU nurses (Shorifi, Jannati, Moghaddam, & Yazdani-Charati, 2016). Because of these factors, the nurse can lose sight of the need to foster a caring relationship with patients and the need to create an environment that is healing for colleagues, for patients and their families, and for the nurse him/herself (Glembocki & Dunn, 2010).

Brewer and Watson (2015) define caring as a mutual, dynamic, transpersonal process between nurses and patients that characterizes optimal patient care. Caring is connected to a sense of physical and emotional safety and has been identified as an essential component of patient satisfaction (Koloroutis, Felgen, & Wessel, 2007). Caring has also been described as the “essence” of nursing (Brewer & Watson, 2015). Nurses strive to provide care that fulfills the individual needs of patients and their families through the integration of affective, cognitive, and action caring processes (Leininger & Madeline, 2006). Person-centered care is driven by knowledge about the patient as a person (Grob, 2013). According to Hardicre (2003), it is knowledge from the patient’s family that enables the nurse to come to know the culture, beliefs, and values of the patient and make culturally congruent decisions regarding nursing care. Studies that have investigated the caring attitudes of critical care nurses reveal that these caring behaviors are intended to provide individualized and holistic care while minimizing the negative effects of the critical care environment (Wilkin & Slevin, 2004).

In the critical care setting, nurses may be confronted by multiple barriers to the expression of caring (Amendolair, 2012). One such barrier is job stress. Critical care environments are stressful due to the complexity of the patient population. Critically ill patients often require life-sustaining technology such as balloon pumps, dialysis machines, heart catheters that render the patient an extension of this technology. Furthermore, this stress may be compounded by the need for ICU nurses to provide end-of-life care and to meet strict standards of regulatory requirements; ICU nurses' job stress may be further exacerbated by ICUs' generally high turnover rates (Fontaine, Haizlip, & Lavandero, 2018). As a result of these barriers, opportunities for nurses to engage in meaningful communication with their patients may be limited and inadequate. Technological advancements hinder caring by limiting the opportunities for improving caring communication, caring involvement, and caring provision of care (Shalaby, Janbi, Mohammed, & Al-Harhi, 2018). Moreover, barriers to the nurses' expression of caring may have adverse consequences beyond those immediately related to the patient. For example, a nurse's repeated experience of barriers to the expression of caring may impair the nurse's ability to find meaning and value in work, and thereby diminish the nurse's job satisfaction (Amendolair, 2012). Fontaine, Haizlip, and Lavandero (2018) showed that in a cohort of 324 nurses, "mattering" and decreased burnout were significantly associated. Mattering is a psychosocial construct that describes when individuals perceive that they make a difference in the lives of others and are significant in the world (Elliott, Kao, & Grant, 2004). In addition, the investigators found that significant antecedents of mattering at work included high-quality connections or caring behaviors with patients (Fontaine et al., 2018).

Critical care nurses frequently struggle to see their patient as more than a diagnosis and to relate to the patient in the bed as a person rather than as an object of professional concern (Brown et al., 2018). Often, patients arrive unconscious or already intubated and sedated, rendering them to be identified as their clinical presentation. In such cases, a nurse's lack of knowledge of the patient as a person affectively distances the nurse from the patient and potentially impairs not only the patients' experience but also the nurses' outlook on their care (Brown et al., 2018).

Clinical use of a patient personalization poster is one approach that can create a relationship between nurses and patients on a cognitive level (Goncalves, Strong, & Nelson, 2016). The posters provide personal information about a patient in a very visible and interactive way, which can help to facilitate patient–caregiver connections (Goncalves et al., 2016). The UCLA Medical Center in Los Angeles saw their scores for “patient confidence and trust in nurses” rise from the 19<sup>th</sup> percentile to the 99<sup>th</sup>, following the implementation of the patient personalization poster (Advisory Board, 2018).

Meaningful communication is the key cornerstone to patient-centered care (Weaver, Bradley, & Brasel, 2012). The critical care nurse is the key contributor of efforts to improve communication with patients and families because these nurses have always been the best advocates for patient-centered care (Peigne et al., 2011). In a nurse's attempt to understand a patient's unique care needs, the nurse's solicitation of personal information about the patient from the patient, from the patient's family, and from the patient's non-family loved ones can be instrumental in improving the patient's health care experience. Creating and confirming

processes such as patient personalization posters that give a voice to the patients are the first step to ensuring care is received in a way optimal to them for facilitating recovery.

### **Problem and Purpose**

Three landmark studies conducted by the Institute of Medicine (IOM) have raised the awareness of both the public and the nursing profession of significant deficits in our health care–delivery model. High quality patient-centered (i.e., patient-centric) care was identified as essential to positive patient outcomes (Institute of Medicine, 2000, 2001, 2004). This degree of overall nursing care impacts the patients’ ultimate safety, outcomes, and experience (Burhans, 2010).

### **Project Site: A Planetree Organization**

The organization that has been identified as the project site for this intervention has been designated as a Planetree organization. The Planetree organization designation recognizes health care organizations that have developed and sustained healing environments that have a positive impact on both the patient and visitor experience of care and the perception of care quality. This is achieved by facilitating personalized choice, dignity, and control. By promoting adaptive use, wellness, and enhancing the safety and nurturing of patients, these organizations are instrumental in activating holistic community health through innovation and evidence-based, sustainable design and operations (Planetree, 2018). A recent analysis of the organization, in relationship to a re-designation of Planetree, revealed “opportunities to personalize the environment” (Planetree, 2018; see Appendix A). Organizational quality data and an appreciative strengths-opportunities-aspirations-results (SOAR) analysis identified the need to enhance nursing caring behaviors and

communication specific to patient personalization for the indicator “opportunities to personalize the environment.”

### **Patient Personalization Posters**

In a nurse’s attempt to understand a patient’s unique care needs, the nurse’s solicitation of personal information about the patient from the patient, from the patient’s family, and from the patient’s non-family loved ones can be instrumental in improving the patient’s health care experience. The use of the “This is My Story” patient personalization posters began as an evidence-based intervention to leverage strengths as identified in this gap analysis, and provide at least one example of how staff accommodate a patient’s personal preference related to their personal environment. The goal of this project was to create a way for hospital staff to get to know patients to form meaningful interpersonal relationships within a busy hospital environment.

### **Problem Statement**

Nurses employed in critical care units face both physical and emotional demands far greater than those experienced by nurses in other disciplines (Sacco, Ciurzynski, Harvey, & Ingersoll, 2015). This is due in part to multifaceted patient complaints, 12-hour shifts in a fast-paced demanding environment, and the ever-present dilemma of competing priorities. This type of work environment has been shown to cause increased stress among critical care nurses (Sacco et al., 2015). Researchers now hypothesize that to combat this stressful environment and the deleterious effects it has on critical care nurses, new strategies that focus on caring behaviors that are based upon an authentic relationship with the patient/family result in positive experiences not only for the nurse but for the patient/family as well (Brewer & Watson, 2015). As such, there has

been a need identified in the literature for interventions such as the “This is My Story” posters that are grounded in caring science and are guided by authentic human-to-human caring (Brewer & Watson, 2015).

### **Purpose Statement**

This evidence-based clinical quality project aimed to increase caring behaviors among critical care nurses and improve patients’ perceptions of caring behaviors while in the critical care environment through the implementation and evaluation of a personalization poster called “This Is My Story.” The proposed “This is My Story” intervention was designed to evaluate a low-tech, simple approach to forming caring relationships quickly and effectively, with an emphasis on the perspective of critically ill patients and their families. The intention was to create a tangible reminder for patients, family, and staff that patients are multidimensional individuals with a rich life experience, dreams, and ideas, and that a caring relationship with patients is the foundation of the healing environment.

The primary objective for the project was to determine if the implementation of patient personalization posters in the ICU of a community hospital would improve the perception of nurses’ caring behaviors. The overall goals are two-fold: (a) demonstrate significant differences in the perception of caring behaviors as measured by the Watson Caritas Patient Score<sup>®</sup> between the Surgical Intensive Care Unit (SICU) and the Medical Intensive Care Unit (MICU) after the implementation of patient personalization posters in the SICU, and (b) achieve 5% improvement in the HCAHPS domain of “nurses communication” rated as “always” based on the initial scores of the progressive care units prior to the beginning of the initiative compared to the scores after implementation of the patient personalization posters. Secondary objectives include identifying if

there were any correlations between aggregate data such as diagnosis and/or length of stay that make the posters more effective in establishing a caring relationship between the nurse and patient. Other secondary objectives were to evaluate the staff satisfaction with the educational process and overall staff satisfaction with the patient posters.

This project integrated the Appreciative Inquiry model, based on Jean Watson's Theory of Human Caring, into the critical care environment to improve caring behaviors as demonstrated by the nursing staff and as perceived by the patients. According to the American Nurses Association, the first step in an evidence-based proposal is to describe the problem in the form of a PICOT question ("Nursing Research", 2017). PICOT stands for population of interest, intervention, current practice, outcome, and time (Melynk & Fineout-Overholt, 2015). The PICOT question that informed the appraisal of evidence was: For adult patients admitted to the surgical intensive care unit (SICU) at Sharp Memorial Hospital, does use of a "This is My Story" poster, as compared to non-use in the medical intensive care unit, improve perceptions of caring behaviors as measured by the Watson Caritas Patient Score?

### **Literature Review**

#### **Purpose/Objectives of the Review**

The literature was reviewed to appraise scholarly articles, dissertations, and books related to the perception of caring as experienced by patients in the critical care setting, specifically with the intervention of patient storyboards. The literature review allowed for a thorough analysis of the concepts related to the PICOT question and to find materials relevant to each concept. In addition, the literature review was useful in determining which research has had significant findings related to caring behaviors and positive patient experiences among critical care patients

as well as barriers that impede the process of meaningful communication within the ICU. In conclusion, the literature review allowed for a discussion of findings and conclusions to support the study being proposed.

### **Literature Search Criteria and Strategies**

A systematic search was conducted for both quantitative and qualitative studies published between 2000 and 2018 using Cochrane, Cumulative Index to Nursing and Allied Health (CINAHL), PubMed, Medline, and Ovid Nursing Journal databases. Articles were limited to the English language. Key search terms used were Appreciative Inquiry, patient-connectedness, nurses caring behaviors, communication barriers, critical care patients, critical care nurses, patient experience, patient centered care, empathy, dehumanization, narratives, storytelling, patient personalization posters, and Watson Caritas Patient Score. Searches also included peer-reviewed journals, Google, Google Scholar, professional organizations' websites, and other resources. Many separate searches were conducted to ensure a comprehensive review was completed.

### **Critical Appraisal of Studies**

**Patient-connectedness.** Connectedness in the nurse–patient relationship is a type of nurse–patient encounter in which needs of the spirit are met with the help of a spiritually competent nurse (Miner-Williams, 2007). It takes place in a milieu of openness and trust in which there is exchange, spiritual guidance by the nurse, and an interpretation of its meaningfulness resulting in an impact on one's life, healing, strength, and/or growth (Miner-Williams, 2007). One of the greatest benefits of nurse-patient connectedness is establishing trust between the nurse and the patient/family (Mitchell, 2007). This trusting relationship fosters

healing and improves patient satisfaction. Satisfied patients frequently have fewer complaints and fewer demands, leading to a more positive experience for both the patient/family and the nurse (Mitchell, 2007).

Patients want warmth and caring as part of the therapeutic interaction. Those nurses who can demonstrate warmth effectively have a positive impact on patient satisfaction (Cleary, 2016). While a nurse may be fully competent to provide care, warmth judgments are made more rapidly than are those about competence and result in a great impact on the overall attitude toward how others are perceived (Cohn, 2018). For patients in the critical care areas, the attributes that lead to patient-connectedness include open dialogue; recognition of the patient as a unique individual; a gentle touch; nurse availability; and a friendly, warm personality (Cohn, 2018). Medvedev and Landhuis (2018) found that hope, spiritual well-being, and quality of life were important issues for critically ill patients and that patients recalled supportive psychosocial interventions even weeks after discharge. Hope, spirituality, and quality of life have been identified as important aspects of hospitalization and psychosocial needs have been significantly correlated with hospital length of stay (Pipe et al., 2008).

Essential to the creation of a connection with a patient/family is the willingness of the nurse to become a healing presence for the patients and their families during a critical illness (Dossey, Keegan, & Barrere, 2016). Nurses can prepare to fully engage with their patient and their patient's family by treating each interaction as purposeful rather than task-oriented (Dossey et al., 2016). When the patient becomes the center of the nurse's focus, the experience becomes communal, shared, and universal (Melia, 2013). As part of this connected experience, the nurse can encourage family members to bring in photographs and other special objects in order to

transform the space from sterile and impersonal to person focused. From a thoughtfully transformed space flows an atmosphere of compassion through which ordinary is changed to sacred by thoughtful attention to the patient and his/her family (Nussbaum, 2003).

In a qualitative study using focus groups of randomly selected patients, families of survivors, and families of patients who died in the ICU, Nelson et al. (2010) used open-ended questions to obtain perceptions of what constitutes high-quality intensive care. They found that a shared definition of high-quality intensive care among the respondents included compassionate communication and decision-making focused on the patients' preferences and values. Lofty Abdel-Aziz (2017) investigated and compared nurses' and families' perceptions of the needs of family members of critically ill patients. A sample of 20 family members and 30 ICU nurses completed the self-administered Critical Care Family Need Inventory (CCFNI). Both nurses and family participants ranked the need for assurance and patient-centered care highest. Meeting the needs of patients' families including treating their loved ones with dignity and respect, which has the effect of the individuals developing trust and increased satisfaction with their hospital care. Loghmani, Borhani, and Abbaszadeh (2014) found that treating patients with a lack of dignity or with a lack of connectedness resulted in poorer health outcomes. In another study, nurses were asked to describe experiences where client dignity had been maintained and experiences where it had been compromised. From these interviews, it was reported that patients should not be seen as an object or body alone (Bailey, Sabbagh, Loiselle, Boileau, & McVey, 2010).

Connectedness is a relevant and important concept to the conceptualization of person-centered care. Reviewing the literature, the multidimensionality of connectedness is evident. Connectedness has been found to be instrumental in our journey and remains a priority in the

context of illness and critical care (Hakanson & Ohlen, 2014). Facilitating opportunities for connectedness between nurses and patients enables patients to be considered as human beings and to “live until they die.” The concept of using narrative stories such as the “This is My Story” personalization poster creates an environment in the ICU that is less detached and enables patients to stay connected to a life that does not only comprise illness and dying (Hakanson & Ohlen, 2016).

**Dehumanization.** The term *dehumanization* refers to the partial or total denial of the humanistic aspects of a person or group (Bailey, 2011). The act of listening to a patient’s heart or chest using a stethoscope and not the ears in the 17<sup>th</sup> century and the act of using a blood pressure monitor in the 21<sup>st</sup> century has been discussed in terms of dehumanizing patients by distancing them from their doctors (Bailey, 2011). The number of these discussions is increasing, as health care becomes more technology driven. Positive arguments focus on the timesaving features of technology in terms of expediting patient examinations and facilitating access to patients; however, the negative side effects of technology use render the patient as a cold, lifeless being disconnected from his/her social and emotional persona (Bailey, 2011).

Patients perceive dehumanization when their existence is excluded from their interactions with others (Bastian & Haslam, 2011). Patients’ relatives feel the same when they think that someone, they deem important is ignored (Bastian & Haslam, 2011). Furthermore, they are disturbed and become angry when they consider themselves treated like objects without human features (Bastian & Haslam, 2011; Haque & Waytz, 2012). Dehumanization decreased satisfaction with and trust in health care providers and decreased patients’ active participation in their care (Haque & Waytz, 2012).

Measures can be taken to remove the negative impacts of dehumanization in health care. Researchers describe the benefits of increased empathy and decreased dehumanization. In one study, 15 radiologists were asked to evaluate x-rays by viewing photos of patients taken. After three months, they were asked to evaluate the same x-rays without seeing the photos. The study determined that while seeing the photos, doctors' empathy levels increased, and they read the films more sensitively, finding five times more results than the previous time (Turner & Hadas-Halpern, 2008). In another study, intensive care unit patients' photos were placed next to their beds. It was found that doctors and nurses were more likely to perceive the patient as an individual, increase communication with the patient, and include the patient in the plan of care (Anderson, Hall-Lord, Wilde-Larson, & Persenius, 2013).

When looking at dehumanization from the opposite lens of humanization, it has been found that care actions, when humanized, assist not only in the recovery and healing of critically ill patients but also in their complete wellness (Reis, Sena, & Fernandes, 2016). Thus, humanization is associated with appreciation and respect for the critical patient, who should be cared for and treated in a special way as to recognize his/her personal preferences and desires (Reis et al., 2016). When patients are not satisfied with their care in the ICU, this is often a reflection of their fear and uncertainty around the diagnosis (Reis et al., 2016). When their health care providers demonstrate affection and emotional support through attention and personalization, the experience of critical care is softened, and patients are satisfied, especially with regard to humanization (Vaes & Muratore, 2013).

For patients to experience humanization in an ICU, health care providers need to find a balance between the need for technological support and low-technology interventions such as

listening and being present (Vaes & Muratore, 2013). Each process of humanization is unique and singular to each individual; therefore, the concept of a patient personalization poster meets the definition of a humanizing intervention (Vedotto & Silva, 2011).

**Patient experience.** Patient experience is can be described as the sum of all interactions defined by an organizational culture that influences patient perceptions surrounding their care (Wolf, Niederhauser, Marshburn, & LaVela, 2014). The Beryl Institute, in its consumer study on patient experience, found that consumers believe that human interactions are the most important variable when assessing the patient experience (Beryl Institute, 2018). In addition, patients surveyed responded that being listened to, communicated with in a way they can understand, and treated with dignity and respect are the three most importance factors influencing their experiences (Beryl Institute, 2018). The importance of the patient experience came to the forefront of health care organizations as the result of the Value-Based Purchasing program and its impact on reimbursement as a measure of performance outcomes (Jha, Oray, Zheng, & Epstein, 2008). However, the patient experience has historically been known to lead to improvements in overall perceptions of care in hospitalized patients (Jha et al., 2008). More recently, studies have shown that significant improvements in the arena of patient experience have led to improved resource utilization, decreased costs, and decreased mortality and morbidity (Fenton, Jerant, Bertakis, & Franks, 2012).

Improvements in the patient experience can be achieved in a variety of ways. These can include new processes, new services, special amenities, and environmental design. However, the most consistent way to improve the patient experience is by providing personalized care for the patients (Kutney-Lee et al., 2009). With this in mind, it is necessary to design and develop

processes such as patient personalization posters that are created with a patient-centered focus (Pipe et al., 2010).

**Patient-centered care.** In its sentinel work *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, the Institute of Medicine (IOM) (2001) identified six characteristics of safe, reliable, and high-quality organizations. These included safety, effectiveness, timeliness, patient-centered, effective, and equitable (Institute of Medicine, 2001). Patient-centered care is defined as an approach and philosophy to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among providers, patients, and families (Abraham & Moretz, 2012). The Institute for Patient and Family Centered Care defines patient-centered care as an approach to the planning, delivery, and evaluation of health care that is grounded in synergistic partnerships among health care providers, patients, and families (Institute for Patient and Family Centered Care, 2010). Four key concepts of the patient-centered care model are respect and dignity for the individuality of the patient and his/her wishes, information sharing between the health care providers and the patient, participation in the decision-making and health care planning processes, and collaboration among all members of the health care team (Institute for Patient and Family Centered Care, 2010).

In 2013, the American Hospital Association (AHA) developed a framework and plan to engage health care organizations in patient-centered care (American Hospital Association, 2013). The Center for Medicare and Medicaid Services (CMS) initiated the Partnership for Patients program that promotes patient and family engagement with the goal of promoting quality and improving patient safety (Agency for Healthcare Research and Quality, 2013). The Agency for Healthcare Research and Quality (AHRQ) (2013) provides support and resources for assisting

hospitals and hospital leaders in implementing patient- and family-centered care with tools for promotion, program planning, and design, as well as evaluation measures. Manary, Staelin, Kosel, Schulman, and Glickman (2015) stated that while having tools and resources are useful in establishing a patient-centered care model, more emphasis needs to be placed on the actual implementation of the elements of patient-centered care and assuring this is translated across all disciplines within the care-delivery process.

The focus on creating high-value health care has created an evolution of measures to link the patient-centeredness, clinical quality, and overall patient satisfaction of care delivered in health care organizations (Zimlichman, Rozenblum, & Millenson, 2013). An increase of patient-centered initiatives has been shown to improve overall metrics in quality, safety, and satisfaction (Groene, 2011). Specifically, these initiatives include better communication, more integrated care-delivery processes, and reduced service-delivery gaps (Dabney & Tzeng, 2013). Hobbs (2009) demonstrated that patient-centered care programs that include therapeutic engagement and interactions among the patient, nurses, physicians, and other providers, with a particular focus on caring, have better outcomes than those that do not. Community hospitals with high levels of patient-centeredness have higher patient satisfaction and reduced costs (Charmel & Frampton, 2008). In a randomized qualitative study, Small et al., (2008) found that patient and family involvement was directly related to services delivered and patient satisfaction. This involvement has proven to reduce adverse events in hospitals by the identification of barriers to quality (Berger, Flickinger, Pfoh, Martinez, & Dy, 2014). Specific to critical care, Cederwall, Olausson, Rose, Naredi, and Ringdal (2018) identified three themes of patient-centered care in mechanically ventilated patients in the intensive care unit. These were finding a person behind

the patient, restoring a patient's sense of control, and the impact of patient involvement related to safeguarding the partnership phase of person-centered care. Facilitating patients to actively participate in decision-making improved the outcomes related to the weaning process from mechanical ventilation.

The outcomes of having a patient-centered focus are that patients will be more loyal, more engaged, and more compliant, resulting in a positive impact to the bottom line (Natale & Gross, 2013). A committed leadership, focused strategic vision, active communication strategies, accountabilities and incentives that promote adoption, and involvement of patients and families in the design process are all key to successful implementation of patient-centered care initiatives (Luxford, Safran, & Delbanco, 2011). The belief that allowing patients and families to participate in their care is disruptive has been disproven in the literature (Prey et al., 2014). Patient-centered care must not only be focused on the patient, but the emphasis should be designed by the patient and for the patient with the best interest of the patient and family at the heart of its design (Grob, 2013). The outcomes of a patient-centered care model that individualizes the plan of care according to the patient's/family's wishes has been demonstrated to improve patient satisfaction and improve perceptions of caring behaviors by staff (Watson, 2012).

**Caring behaviors.** Caring has been identified as an essential component to patient satisfaction and a sense of physical and emotional safety (Koloroutis, Felgen, & Wessel, 2007). Caring has also been described as the moral ideal of nursing and is the very foundation of nursing care (Watson & Brewer, 2015). Moreover, caring is the primary intellectual, theoretical, heuristic, and core central to the nursing profession (Moghaddasian, Dizaji, & Mahmoudi, 2013).

Caring behaviors may include a wide variety of expressions, including words, thoughts, feelings, looks, actions, movement, gestures, body language, touch, acts, procedures, and/or information (Watson & Brewer, 2015). Therefore, caring is the personal, spiritual, moral, and social involvement of the nurse as he/she commits to self, co-workers, and patients (Makic, 2017).

According to Watson (2012), nurses' caring behaviors may be influenced by external factors, which may include patient's diagnosis, type of care setting, nurse's age and experience, self-respect, beliefs, and workplace culture. The literature also shows that there are differences in caring behaviors among different cultural groups (Modic, Siedlecki, Griffin, & Fitzpatrick, 2016). Other research has demonstrated that nursing care assignments, lack of time, and a lack of caring support contribute significantly to nurses' caring behaviors (Amendolair, 2012).

**Critical care nurses and caring behaviors.** Critical care nurses' practice encompasses providing direct, individualized, holistic care to meet the bio-psycho-social needs of critically ill patients and their families in the context of caring processes. Available studies focusing on caring-oriented behaviors in critical care settings have described how critical care nurses demonstrate caring behaviors in the face of this complex environment (Munger et al., 2012). Within the context of the critical care environment, nurses are challenged by ethical considerations, continued advancements in technology, and the rapidly changing face of health care in general, all of which are contributing to conflict in the role of the nurse as it relates to caring behaviors (Amendolair, 2012).

The use of advanced technology within the critical care environment can limit the opportunities for demonstrating caring behaviors by critical care nurses (McGrath, 2008). Research has shown that when nurses are caring for patients who require a large amount of

technical maintenance, the view of the patient as a person can be diminished (Tunlind, Granstrom, & Engstrom, 2015). There has been some concern within the realm of critical care nursing that the demands of the technological environment may be creating barriers in nurses' ability to focus on the human aspect of caring (Weyant et al., 2017). In their study, Weyant et al. (2017) explored perceptions of nurses' caring behaviors among intubated patients and their family members. A phenomenological study of 14 patients who were intubated, restrained, sedated, and received pain medication in a cardiovascular intensive care unit was conducted. In this study, patients and families described how nurses were present for them. The concept of presence encompassed an overall demeanor and attitude. Nurses' presence and caring behaviors were found to be synonymous with each other. Nurses who demonstrated caring behaviors allowed themselves to become personally involved with patients and patients' families. In a study by Alasad and Ahmad (2005), critical care nurses conveyed that while communication is a priority, it often becomes diminished in the face of all that is needed to be done for the patient. If caring for a patient is perceived as a task to be completed, then communication is hindered, becomes rehearsed, and lacks emotion. In a trauma ICU, nurse participants in a pilot study reported that communication with the patient was mostly done during task-oriented activities (Villaneuva, 1999). Because of the lingering threat of death in critical care, physical needs are seen as a priority compared with psychological needs, but it does not mean both cannot be addressed (Munger et al., 2012).

The presumption that an unresponsive patient will not benefit from interaction with his/her nurse is an attitude that can inhibit therapeutic conversations. According to Bagherian, Sabzevari, Mirzaei, and Ravary (2017), it may be difficult for the nurse to maintain a caring

attitude if the patient is not able to communicate back to the nurse. This notion leads to reduced motivation for the nurse to speak to his/her patient if the patient will not converse back or show any other physical sign of acknowledgement (Alasad & Ahmad, 2005). Preferring to care for mechanically ventilated and sedated patients is an attitude of some nurses that can prevent the delivery of holistic, person-centered care (Bagherian et al., 2017). When the nurse enters the room with a preconceived notion that they are going to have an “easy” day caring for an unresponsive patient, communication may be strained when the nurse instead finds an assigned verbal patient. In either case, caring for an unconscious or conscious patient should include personalized communication as part of the patient’s plan of care. Finfged-Connett (2008) states that nurse–patient communication can help patients in their recovery and can contribute to feelings of caring fulfillment for the nurse, resulting in a mutually beneficial patient interaction.

**Empathy.** Empathy has become an important concept amongst health care leaders as they seek to improve patient care, secondary to the Affordable Care Act (ACA) (Eckman & Krasner, 2016). The nursing profession has evolved from a task-oriented focus on patient care to a more holistic approach with the patient at the center of the nurse-patient relationship (Tunlind, Granstrom, & Engstrom, 2015). Areas that have been identified as potential concern with the empathic relationship of a nurse and patient relate to consent, patient advocacy, confidentiality, and empowerment of patients (Tunling et al., 2015). Any new intervention designed to the nurse–patient relationship and therefore the patient’s opinion of his/her care could be considered a liability, as the patient may be unduly influenced by the relationship with the nurse or the requirements of the health care organization (Cornwell, 2017). Nonetheless, empathy and patient-centered care have been associated with better patient outcomes. Researchers who

collected data on active listening, self-awareness, empathy, and patient-centered care from 53 nursing students found that active listening and self-awareness were significantly associated with empathy. Empathy was significantly associated with patient-centered care and was found to be at the core of the relationship between self-awareness and patient-centered care (Haley et al., 2017).

Watson's theory of human caring (Watson, 2009) is grounded in the basic empathic relationship between a nurse and patient. The theory describes the relationship in terms of relationship-based nursing (RBN). The core of this concept is empathy. According to Watson (2009), empathy is defined as the ability of the nurse to understand a patient's feelings, while appreciating the patient's perspective and using these to effectively communicate with the patient. Empathy has been identified as an essential quality that every nurse should possess to provide patient-centered care (Mathad, Pradhan, & Rajesh, 2017).

**Patient stories and narratives.** Narrative medicine is a discipline that has been progressively incorporated into medical training in an effort to restore the physician–patient relationship (Facioli, Amorim, & Almeida, 2012). The patient is viewed as not merely a diagnosis, but a person with a story that evokes emotions in those who care for him or her. Narrative medicine is the ability to acknowledge, to absorb, to interpret, and to respond to a person's story (Facioli et al., 2012). It strengthens empathy, rescues patient individuality, and facilitates solutions to conflicts in complex settings such as critical care units where providers are challenged daily by both moral and ethical issues (Facioli et al., 2012). To preserve the uniqueness of the provider–patient relationship, clinicians must develop the ability to listen to stories and to understand and honor their meanings. This is narrative competence: the capacity of human beings to acknowledge, to absorb, to interpret, and to react to stories (Facioli et al., 2012).

Narrative medicine uses patient stories as a diagnostic, therapeutic, and educational tool. The patient is not seen as merely a case of a disease, but as a story that arouses feelings in those who assist him or her (Charon, 2001). Clinicians who are able to narrate and to reflect on their feelings can provide more conscientious, humane, and compassionate care and are more accessible, generous, and helpful to their patients (Basrai, 2018). Narrative medicine can be quite useful in the critical care environment because of the moral, ethical, legal, social, religious, and economic conflicts that directly affect the feelings, emotions, and psychological defense mechanisms of caregivers (Basrai, 2018).

To provide a way for hospital staff to form meaningful therapeutic relationships with patients, a life story intervention consisting of a “Tree of Life” poster was introduced in a population of hospitalized older adults (Pipe, Mishark, Hanse, Hentz, & Hartsell, 2010). The “Tree of Life” poster depicted sources of encouragement and enjoyment, special memories, life lessons, family, and roots for the patient. Pre-intervention and post-intervention measures included quality of life (QOL) and spirituality scales. A one-sample t test was used to analyze the data. Improvements were noted in overall QOL, as well as emotional, physical, and spiritual well-being as measured by the Expanded Version of the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (Pipe et al., 2010).

A similar study demonstrated comparable results when the researchers investigated the relationship between nurses’ caring behavior scores and the use of the “Get to Know Me” poster with hospitalized older adults (Goncalves, Strong, & Nelson, 2016). Using a two-group quasi-experimental pretest-posttest design, nurses’ caring behavior scores, for the nurses in the experimental group who utilized the “Get to Know Me” poster, were significantly higher on the

total Caring Assessment of Care Givers (CACG) instrument than those nurses in the control group. In addition, the experimental group scored significantly higher on the sub-scale dimensions of maintaining belief, being with, and doing for than those nurses forming the control group (Goncalves et al., 2016). In 2017, Borce and Thorkelsson (2017) implemented a quality improvement project in the ICU called “My Story.” The intent of this project was to collect nontraditional information about the patients admitted to a critical care unit. This was achieved by asking patients and/or families to fill out the “My Story” board. Post-implementation, they found significant consensus that both patients and family members felt more humanized and less like a bed number. In addition, they felt that their critical care experience was more endurable because their care providers connected with them on a level beyond their illness.

### **Summary of the Literature**

A comprehensive analysis of the literature was undertaken, and the merits of the research were graded using the John’s Hopkins evidence appraisal tool (See Appendix B). Of the four articles specifically related to patient personalization posters, three were rated as Level III (A) (Goncalves et al., 2016; Pipe et al., 2010). The remaining article was a Level IV (B) (Borce & Thorkelsson, 2017). Evidence based projects based on human caring theory has provided nurse leaders the opportunity to evaluate the effectiveness of professional practice environments (Brewer & Watson, 2015).

The review of the literature on the impact of patient personalization posters as an adjunct to increase patients’ perceptions of nurses’ caring behaviors in the critical care setting has

demonstrated that the “This is My Story” intervention is supported and needed in this population (Borce & Thorkelsson, 2017; Goncalves et al., 2016; Pipe et al., 2010). It is a relatively low-cost and simple intervention that could yield significant positive outcomes in terms of patient satisfaction (Goncalves et al., 2016). Patients entering the critical care environment experience both physical and psychological stress that may lead to co-morbidities.

This review has suggested that a connection with the patient through the use of a story may assist in combating these stressors that could lead to poor outcomes (Basrai, 2018; Borce & Thorkelsson 2017; Facioli et al., 2012; Goncalves et al., 2016; Pipe et al., 2010). As this review identified, much research has addressed communicating with families in the ICU; however, there is much left to be explored (Lofty Abdel-Aziz, 2017; Bailey et al., 2010; Cohn, 2018; Dossey et al., 2016; Loghmani, Borhani, & Abbaszadeh, 2014; Nelson et al., 2010). We are at a time in the health care paradigm when the patient, not the provider or the institution, should be at the center of our care. As we move toward more patient-centered models of care, patients and their families can guide us in providing this caring environment.

The literature does not reflect the spirit or components of nurses’ caring behaviors. Patient satisfaction measurement tools to date do not the caring that nurses provide and as such the essence of nursing practice goes unacknowledged (Brewer & Watson, 2015). Tools such as the “This is My Story” posters can capture the caring behaviors that nurses engage in that contribute to the healing and safety of patients. Data from projects such as this one can contribute to understanding what is perceived by our patients and families as caring and contribute to recovery as perceived by those in crisis and high-technology environments.

Capturing these data is elemental to facilitating the design of healing environments that humanize the patient experience.

### **Definition of Key Terms**

- Appreciative Inquiry- an approach to change that utilizes positive inquiry, or questions, to determine what individuals and teams appreciate, or value, to discover the best of the organization (Moorer et al., 2017).
- Patient-connectedness- the nurse–patient relationship in which needs of the spirit are met with the help of a spiritually competent nurse (Miner-Williams, 2007).
- Nurses’ caring behaviors- personal, spiritual, moral, and social involvement of a nurse, as he/she commits to self, health team members, and patients (Watson, 2009).
- Patient experience- the sum of all interactions defined by an organizational culture that influences patients’ perceptions surrounding their care (Wolf et al., 2014).
- Patient-centered care- an approach and philosophy to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among providers, patients, and families (Abraham & Moretz, 2012).
- Empathy- the ability of the nurse to understand a patient’s feelings, while appreciating the patient’s perspective and using these to effectively communicate with the patient (Watson, 2009).
- Dehumanization- the partial or total denial of the humanistic aspects of a person or group (*Humiliation, Degradation, Dehumanization*, 2011).

- Narrative competence- the capacity of human beings to acknowledge, to absorb, to interpret, and to react to stories (Facioli et al., 2012).
- Patient personalization poster- the collection of nontraditional information about a patient for providing health care staff a means to connect with their patient (Goncalves et al., 2016).
- Watson Caritas Patient Score<sup>®</sup>- a reliable and valid instrument used in hospitals and systems throughout the United States to assess perspectives of caring practices of hospital staff, of colleagues and peers ([watsoncaringscience.org](http://watsoncaringscience.org))

### **Theoretical Framework**

According to Moran, Burson, and Conrad (2014), a theoretical framework provides guidance for project management, defines variables, and provides a structure for evaluating outcomes. It also enhances understanding of relationships among concepts and provides focus for the project organizer. The theoretical frameworks of Appreciative Inquiry (2019) and Watson's (2012) theory of human caring guided the design and study of this quality improvement intervention. Alignment of these two theories in conjunction with an intervention to personalize the patient experience was implemented to allow the participants, both the patient and nurse, the ability to connect with the emotional and subjective aspects of nursing. This connection will enhance the caring relationship through communication and understanding, which can develop and maintain the harmony and trust necessary for effective patient care.

**Watson's Theory of Human Caring**

Watson's (2012) theory of human caring is built on core aspects that include the 10 Caritas processes, previously called carative factors, developed to support the nursing discipline by informing the professional practice of nurses toward delivering quality care and fostering authentic healing relationships. These practices are:

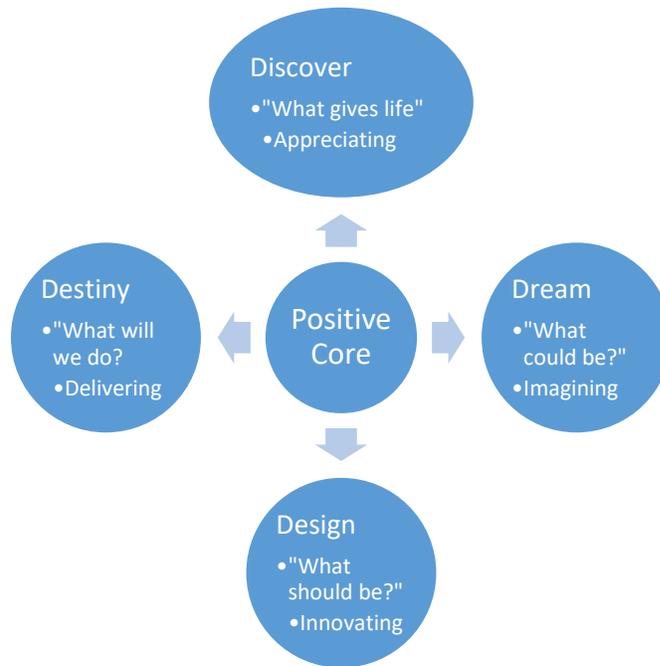
1. Practicing loving kindness and equanimity within the context of caring consciousness.
2. Being authentically present, enabling, and sustaining the deep belief system of self and one-being-care-for.
3. Cultivating one's own spiritual practices and transpersonal self, going beyond ego-self.
4. Developing and sustaining helping-trusting authentic caring relationships.
5. Being present to, and supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and one-being-cared-for.
6. Creatively using self and all ways of knowing as part of the caring processes; engaging in artistry of caring healing practices.
7. Engaging in genuine teaching-learning experiences that attend to unity of being and meaning.
8. Creating a healing environment at all levels (physical as well as non-physical, subtle environment of energy and consciousness), whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assisting with basic needs, with an intentional caring consciousness; administering "human care essentials," which potentiate alignment of mind-body-spirit, wholeness, and unity of being in all aspects of care.

10. Opening and attending to spiritual-mysterious and existential dimensions of one's own-life-death; soul care for self and the one-being-care-for.

Watson's (2012) Theory of Human Caring emphasizes the importance of the transpersonal relationship between patients and their families, and nurses or other members of the care team. A mutual, dynamic, transpersonal process between nurses and patients characterizes optimal patient care. This transpersonal process requires nurses and other health team members to both care for and care about their patients. Ideally, the transpersonal process includes attentiveness to the emotional-spiritual relationship with patients. Accomplishing the tasks of care delivery remains a powerful undercurrent of the work culture in most nursing departments, which may tend to de-emphasize the "non-task" work of creating a caring relationship. Watson's theory has been used to guide intentional efforts directed toward creating healing environments that support caring behaviors in the context of professional nursing practice (Brewer & Watson, 2015).

### **Quality Improvement Framework: Appreciative Inquiry**

Appreciative Inquiry (AI) is an innovative and unique approach to approaching organizational change (Barrett & Fry, 2008). In contrast to traditional change management methodologies that focus on problems, gap-reduction strategies, and "fix-it" solutions, AI facilitates change through discovering and valuing the strengths, assets, vision, and ideals of individuals within an organization (Watkins, Dewar, & Kennedy, 2016). By appreciating core strengths and values, factors within an organization that define meaning and value to work are identified and with this identification, participants are then inspired to take collective action toward reaching a shared vision (Barrett & Fry, 2008). Appreciative Inquiry utilizes four iterative phases that occur in sequence (See Figure 1).



*Figure 1. Appreciative Inquiry model*

These phases are called the 4D-cycle: discovery, dream, design, and delivery (Havens, Wood, & Leeman, 2006). During the discovery phase, the AI process focuses on interviews designed to bring to light the organization's positive capacity related to the proposed change to discover what is working. The interview questions are purposeful in their methodology and traverse a backward, inward, and forward flow (Havens et al., 2006). In this project, the foci for AI are patient-connectedness, nurses' caring behaviors, and barriers to meaningful connections/communication with patients in the ICU.

During the dream phase, the AI process focuses on the stories that were revealed during the interviews. An assessment of these stories will reveal the key positive attributes and skills that are already present in the organization. These positive concepts are then expanded into a compelling future state that is disseminated to other stakeholders. This future state then becomes

the platform from which action plans are developed. For this project, AI concepts that could be explored may be framed around the question, “If you could have a true connection with your patient, what would it look like?”

The design phase is composed of the teams looking at processes and structures that need to be in place for the dream to become realized (Havens et al., 2006). Design elements can include changes to committee structures, policies and procedures, meeting formats, recognition methods, communication links, position descriptions, scheduling processes, and much more (Havens et al., 2006). In terms of this project, key stakeholders such as critical care nurses may provide input into the narrative storyboards based on their experiences and desires to create a more caring environment.

Lastly, the delivery/destiny phase reinforces the change by creating a culture that continually notices what positive changes have occurred within the construct of everyday conversations. This piece of the AI process mirrors the high reliability concepts that the organization already embodies, saying what they are doing right and noticing what others are doing well. With an ongoing focus on seeking out the positive, relationships are built, and design structures and processes are sustained, based on the best attributes of the hospital (Havens et al., 2006).

Appreciative Inquiry has been used by one hospital’s Patient Experience Team to drive its patient experience as reflected in Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) scores, and improve its image, brand, and reputation (Moorer et al., 2017). The hospital’s leadership turned to the theories of Appreciative Inquiry to create a

framework that supported its patient experience initiatives. HCAHPS scores were used to measure the results of these initiatives. The domain of willingness to recommend the hospital was tracked to measure overall success of the team's initiatives. Over the course of a year, these scores increased from 68.9% to 74.4% (Moorer et al., 2017).

The literature suggests that organizational or departmental change initiatives are more successful when the organizational context is receptive to change (Northouse, 2016). In addition, organizational change is most successful when the change process has a multilevel, multidisciplinary focus (Northouse, 2016). AI is appropriate for this project as a theoretical model, as its intent is to "reach" or "touch" as many staff disciplines and departments as possible to promote caring behaviors and improve patient connectedness with meaningful conversations that are centered on the patient as a human being with dreams, passions, and a life story.

### **Project Design and Implementation**

#### **Goal of the Project**

Although many health care innovations are highly technical, due to the complexity of the ICU environment, this quality improvement project was designed to use a simple, low-tech intervention that could be easily replicated in a variety of nursing care settings. The project explored the feasibility and impact of a "This is My Story" patient personalization poster on the perception of nurses' caring behaviors by the patient/family of critically ill individuals. This project was in alignment with the organization's affiliation as a designated Planetree entity, of which personalizing the patient's care was identified as an opportunity to leverage strengths within the organization related to "personalizing the environment" during plans for re-

designation. The anticipated results are that the perception of critical care nurses' caring behaviors will be significantly improved when they use the patient storyboards to connect on a personal level with their patients. In addition, it is anticipated that the patient satisfaction scores (HCAHPS) of units that the patients transfer to after their critical care stay will be improved as well. Particularly, the indicator: Nurses always communicated well (See Appendix C). These scores have been identified as not meeting the organization's objective of achieving patient satisfaction scores equal or greater than 90<sup>th</sup> percentile across all 11 domains. The scores respectively on each unit impacted are as follows: 4 West (23), 5 West (87), 6 West (95), and 7 West (77) (See Appendix D).

### **Setting**

The DNP scholarly project took place at community hospital in California. This hospital is dedicated to providing the highest quality, patient-centered care. Designed to promote comfort and healing with the use of natural light and soothing colors, the 368-bed hospital offers the latest medical technology and is home to the communities largest emergency and trauma center. The hospital is a Magnet-designated hospital for nursing excellence and is designated as a Patient-Centered Hospital by the international patient advocacy group, Planetree, Inc.

Specifically, the project was conducted in the Surgical Intensive Care Unit (SICU) and the Medical Intensive Care Unit (MICU). Each unit has 24 beds, with a diverse patient population, including patients receiving treatment related to cardio-vascular surgery, heart

transplant, trauma, general surgery, neuro-surgery, and chronic medical conditions such as diabetes, renal failure, and sepsis. In addition, extra-corporeal membrane oxygenation (ECMO) is offered as an adjunctive therapy for patients who need mechanical assist support post-arrest and/or while waiting on organ transplantation. Both critical care units have been designated as Silver Beacon Award recipients in recognition for their commitment and dedication to continuous quality improvement and patient outcomes. Four progressive care units receive patients from the two ICU settings. Each of these units comprises 32 beds and is designated for a specialty population. The patient personalization posters accompanied each patient to his/her transfer unit.

### **Population**

The patient population for this project was a convenience sample of all patients who were 18 years of age and older and admitted to the critical care unit(s), the MICU, or the SICU during the project timeframe. Patients who were in police custody and/or in the custody of immigration officers will be excluded from the study. Based on fiscal year 2018 census data, the MICU had 922 admissions and the SICU had 716 admissions. This translates into 76 admissions per month in the MICU and 60 admissions per month in the SICU. It was anticipated that around 400 patients would potentially receive the intervention. The family members of patients, if present, will be included in the discussion and their participation will be documented on the data collection tool. The MICU employs 110 registered nurses and 8 nursing assistants called “Health Care Partners” (HCPs), and the SICU employs 118 registered nurses and 8 HCPs. The total number of participants for the project was estimated to be 650.

## **Intervention & Implementation**

### **Planning the Intervention**

One of the major roles that a health care leader performs is that of change agent (Northouse, 2016). In the current climate of health care that is faced with financial constraints, workforce shortages, and a focus on quality of care, creating an environment that allows staff to focus on providing patient-centered care not only improves the perception of the care, but also fosters autonomy, interdisciplinary collaboration, and engagement (Macdavitt, Cieplinski, & Walker, 2011). Creating a culture that supports change requires leaders who are dedicated and accountable to creating a new health care environment (VanGorder, 2015). To create a positive environment for change, the principles of Appreciative Inquiry were incorporated into the change process, where the focus was on appreciation of past practices, envisioning the future, engaging discussions of what should be and innovating and implementing practices to meet these ideal goals for the future.

The initial step of any planned change is the planning process or discovery phase when done within the framework of Appreciative Inquiry. This step includes evaluating the environment, setting measurable goals and objectives, and setting a timeline for the process. The creation of a shared vision cannot be accomplished without support and buy-in from staff. As the idea for the project was being discussed, testimony from patients and family members relating their experience in the ICU was informally elicited. In addition, staff members were asked what would allow them to better create a connection with their patients. Sharing these stories, staff were able to articulate the need for a way to “know” the patient as they were before the hospitalization. In this respect, the dream step of the AI process was realized.

**Project Plan**

With the upcoming Planetree re-designation and the opportunity to leverage strengths within the organization related to “patient preferences,” during a meeting with the Vice-president of Professional Nursing Practice and the Chief Nursing Officer, the idea for this project was discussed based on the discovery and dream work that had been done in the MICU and the SICU that had identified this intervention. A sample patient personalization board was used for a comatose patient as an example of the intervention and this was shared with the Chief Nursing Officer during rounds. She endorsed the project and gave approval to proceed with the development of the posters and the implementation of the project. The project was then presented to the department managers and was approved. A meeting was scheduled with the marketing department to plan the design of the poster. Final approval was received by presenting the project proposal at the “New Knowledge and Innovation” (NKI) council at the organization on August 27, 2018. The original design of this project was to implement the posters in both the SICU and the MICU. A pre-implementation baseline of each unit was anticipated to be done with the Watson Caritas Patient Score<sup>®</sup>, followed by a post-intervention assessment of each patient who participated. At the NKI presentation, the stakeholders suggested that the data collection plan include a pilot unit (SICU) and a control unit (MICU). This would allow for the comparison of data during the intervention. They believe this approach is necessary for the project to have longevity and sustainability within the organization.

**Implementation**

The timeline for this project was nine months. In month one and two (July–August 2018), the project idea was formulated with frontline staff using the AI approach. Once the idea was

generated, the sample poster was created and trialed in a patient room for the CNO to evaluate. A meeting was conducted with marketing to discuss the design of the poster and proposed materials. A deadline of September 15, 2018 was set for a proof to be completed. This customized template for the patient personalization poster aligned with the organization's marketing strategic plan, emphasizing the "Patient Experience" (see Appendix E).

Before implementing the patient personalization posters, staff buy-in was established to ensure that they understand the goal and potential impact of the posters. This buy-in was done by attending huddles with all unit nursing staff who were impacted by the posters. These huddles occurred daily at 7:00 a.m. and 7:00 p.m. for each unit. Over the course of two weeks, staff were informed. During the huddles, each participant received a poster and a pen. Each participant collaborated with a peer and completed his/her own poster. The following discussion prompts were available to stimulate conversation surrounding the posters:

1. What did you learn about your peer through this exercise?
2. How much did you already know? What was new?
3. How will this change the way you work together in the future?
4. How might your patients feel after completing a poster?
5. How might learning about your patient through the poster change how you deliver care?

Ancillary departments as well as the physician groups received a flyer during October detailing the intervention and ways, they could engage the patient using the "This is My Story" posters

(see Appendix F). Planned attendance at the huddles for housekeeping, respiratory care, and physical therapy were scheduled with the respective managers and conducted. The physicians were informed during the monthly critical care committee meeting held on the first Monday of every month.

The implementation of the posters was anticipated to begin November 1, 2018 and continue through January 31, 2019. However, due to a delay with the Institutional Review Board, the end date of the project was pushed back to February 2019. A sufficient supply of posters was ordered and on hand for the three-month implementation period. Staff were educated on where to find the posters. The posters were to be placed in the patient rooms as the rooms were being prepared for a patient admission. Other unit managers and transport staff were informed that patients being transferred from the critical care units would be accompanied by a patient personalization poster and that the poster should be hung in the room in a visible location. Adding poster handoff to the unit's discharge planning checklist ensured that the posters traveled across the facility with the patient.

Nursing staff determined who is able to complete the poster. For example, a family member or friend may be best suited for ventilated and/or sedated or unconscious patients. Patients may complete the poster themselves if willing and able. Once the appropriate person was identified, they were assessed for their interest in participating. The following script was used to explain the purpose of the posters:

- **What the patient personalization poster is:** The patient personalization poster is this poster that you see on the wall. Once filled out, it enables me and everyone else on the unit to get to know you/your loved one better as a person and for us to

- customize your/your loved one's care. It includes information about you/your loved one's interests, aspirations, and anything else you would like to include.
- **How the information will be used:** The information you provide will appear on the poster. The poster will stay with you/your loved one while you/your loved one is in the hospital, but you are welcome to take it home when you/your loved one leaves.
- **Participation is optional:** If you do not feel comfortable filling out the poster, it is not a problem.
- **Owner of poster completion:** Do you think that you would like to take the time to complete this poster?

Once the patient personalization posters were implemented on the units, most patients had a poster in their room. The following steps were used by staff to incorporate the posters into their daily practice:

1. **Look for the Poster.** Enter the patient's room and look for the poster.
2. **Use the Poster as a conversation starter.** Review the completed poster and use the information you learned as a starting point for conversation. For example, you may find that you and your patient share the same hobbies or follow the same sports team. Potential conversation starters can be gleaned from the poster by mentioning an interest that you and the patient have in common, asking the patient and family to tell

you more about something that seems unusual or remarking on something they are proud of or a special accomplishment.

When the patient is transferred to another unit, the poster will be sent with the patient. If the patient is being discharged from the hospital, it will be part of the discharge process to ensure that the poster goes home with the patient.

### **Timeline**

A Gantt chart was developed to show critical elements of the project and identify significant milestones that must be completed for the success of the project. This chart required updates throughout the process to accommodate barriers to implementation that were encountered during the project. This chart highlights various objectives that were met and describes the overall goal of the project divided into sections related to the AI process: Discover, Dream, Design, and Destiny (See Appendix G).

### **Evaluation & Data Analysis Plan**

#### **Evaluation Plan**

The primary objective for the project was to determine if the implementation of patient personalization posters in the ICU of a community hospital would improve the perception of nurses' caring behaviors. The overall goals were two-fold: (a) demonstrate significant differences in the perception of caring behaviors as measured by the Watson Caritas Patient Score<sup>®</sup> between the Surgical Intensive Care Unit (SICU) and the Medical Intensive Care Unit (MICU) after the implementation of patient personalization posters in the SICU, and (b) achieve 5% improvement in the HCAHPS domain of nurses' communication, rated as "always" based on the initial scores of the progressive care units prior to the beginning of the initiative compared to

the scores after implementation of the patient personalization posters. Secondary objectives include identifying if there were any correlations between aggregate data such as diagnosis and/or length of stay that made the posters more effective in establishing a caring relationship between the nurse and patient. Other secondary objectives were to evaluate the staff satisfaction with the educational process and overall staff satisfaction with the patient posters.

After the staff education, the patient personalization posters were introduced in the SICU. Completion of the posters by the patient and/or family indicated implied consent. During the three-month project period (December 2018–February 2019), each patient in the SICU who participated in the study and completed a patient personalization poster was anticipated to be surveyed using the Watson Caritas Patient Score<sup>®</sup> upon discharge or transfer from the unit. For comparison purposes, each patient that transferred or discharged from the MICU during the study timeframe was also anticipated to be surveyed using the Watson Caritas Patient Score<sup>®</sup>. In addition, demographic information for both the SICU and the MICU patients was collected, including age, gender, race, diagnosis, length of ICU stay, who completed the poster (family or patient), and the unit to which the patient transferred. The SICU patients also had a question that captured the unit to which they transferred so that an analysis of HCAHPS scores could be done after the project completion. A standardized data collection tool was developed to capture this information and was initially intended to be completed by the transferring nurse (see Appendix D). However, during the data collection, barriers were identified that precluded the bedside nurse from collecting the data. One of these was the perceived reluctance of the patient/family to honestly answer the questions in the presence of their caregiver. As a result, the principal investigator assumed responsibility for the data collection on both units. Since the tool

was only used to collect aggregate data, there were no concerns around interrater reliability. There were no patient identifiers on the tool. The data collection tool and the Watson Caritas Patient Score<sup>®</sup> tool were correlated using a subject ID. The data were entered into an Excel spreadsheet on a computer that was in a locked office at the practice site, and saved to the organization's password-protected, encrypted server. All data sharing with the Jacksonville University (JU) statistician and project chair was done via a JU OneDrive shared folder, which is cloud based and password protected via the JU system.

The Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) scores of the receiving units were used to determine if there were positive downstream effects of the posters on the units that received patients who had completed posters. The HCAHPS scores are publicly reported in the organization and are found on the quality dashboard on the intranet site. These were compared during the month preceding the intervention and the month following the completion of the project.

To determine the effectiveness of the education about the posters and their implementation, staff were given an evaluation tool to complete (see Appendix J). This ensured that the implementation of the posters was conducted in the way it was intended. Another process measure that was assessed was staff satisfaction with the posters, via a survey administered at the end of the project. This was administered to the nursing staff in the SICU (see Appendix K).

### **Data Analysis Plan**

The measurement assessment was conducted using the Watson Caritas Patient Score<sup>®</sup> (WCPS), capturing the patient's experience of caring. The five items of the WCPS emerged from

the Watson theory of 10 Caritas Processes as universals of caring phenomenon and foundational indicators of human caring (Watson, 2009). Response options for each item range from 1 (never) to 7 (always). The items empirically assess the patient's subjective experience of receiving caring; the items refer to such indicators as loving kindness, trust, dignity, healing environment, and honoring of beliefs and values. The WCPS instrument is designed to capture patient perceptions of caring practices of their caregivers. The scale, which hospitalized patients have reported to be simple to complete, has exhibited excellent reliability and validity (Watson, 2009). The scale demonstrates satisfactory internal consistency and reliability (Cronbach's  $\alpha=.90$ ; Brewer & Watson, 2015). Construct validity has been evaluated using an exploratory factor analysis with principal components using varimax rotation, which resulted in a single factor explaining 76% of the variance (Brewer & Watson, 2015). The factor loading for the item, "create a caring environment that helps me to heal" was 0.906 (Brewer & Watson, 2015). Comparisons of the nurses' caring behaviors obtained with the Watson Caritas Patient Score<sup>©</sup> was done to determine if there were significant differences between the SICU (poster) and the MICU (no poster). Each of the five items in the WCPS has been demonstrated to correlate with HCAHPS scores (Brewer & Watson, 2015).

The second measure that was used for this project is a six-question demographic survey, which asks standard questions such as race, age, reason for hospitalization, length of ICU stay, who completed the poster (family or patient), and the unit to which the patient transferred (SICU only). These data were collected for both the SICU patients and the MICU patients, for comparison. Summary tables (descriptive statistics and/or frequency tables) are provided by ICU (SICU vs. MICU) for all key variables (i.e. patient characteristics, WCPS

score by item, and the mean scores of each of the five items). Continuous variables are summarized with descriptive statistics (n, mean, standard deviation (SD), median, minimum, and maximum). Frequency count and percentage of subjects within each category are provided for categorical data. WCPS scores, calculated by patient as the mean score of each of the five items, were analyzed using a linear regression to test for significant difference between the SICU (poster) and the MICU (no poster). ICU type (medical vs. surgical) and patient characteristics such as age, gender, race, and length of stay were included in the model as fixed effects. Comparisons between the two ICU types were conducted using a t-test on least-square means.

Lastly, HCAHPS scores were compared pre- and post-intervention of the four progressive care units that receive ICU patients. The HCAHPS is recognized by the Centers for Medicare and Medicaid Services (CMS) as the standardized instrument utilized to measure the level of patient experience in the hospital setting (CMS). The HCAHPS survey consists of 32 questions, of which there are 25 related to the experience of care and 7 personal questions about the demographics of the person completing the survey. The 25 experience of care questions have a Likert-based answer, consisting of always, sometimes, usually, or never (See Appendix C). These data are reported to CMS, and the survey is performed through an independent contractor, Avatar Solutions, which is certified to mail, collect, analyze, and report the HCAHPS data to CMS quarterly and to the organization monthly. Manary, Boulding, and Staelin (2013) reported that patient satisfaction, when measured with well-designed survey instruments that prompt patients to report their specific health care experiences rather than their overall feelings, is associated with quality of care. Their research group found that the three assessment survey factors most highly correlated with patient satisfaction in a hospital setting were communication

with nurses, pain management, and timeliness of assistance (Manary et al., 2013). These data are summarized descriptively by period of intervention (pre vs. post) and analyzed for at least a 5% improvement over baseline scores between the pre-intervention and post-intervention scores in the Progressive Care Units (PCU) units scores related to “nurses’ communication.” All statistical analysis was conducted at a 5% significance level using R version 3.4 or higher (R Foundation for Statistical Computing, Vienna, Austria) and/or SAS version 9.4 or higher (SAS Institute Inc., Cary, NC).

### **Stakeholder Assessment**

Identification of the major stakeholders as part of the project proposal and analysis was conducted. Stakeholder feedback is critical to implement any change, and was elicited as part of the discover, dream, and design phases of this project. The identification of the stakeholders was also important to develop the education and communication plan to provide a guide to deliver information and results to various groups. The primary stakeholders were identified as patients and families, nurses, and health care allied staff. Secondary stakeholders included the nursing leadership team, physicians, and the Planetree coordinator for the site.

### **Organizational Analysis**

A strengths, weaknesses, opportunities, and threats (SWOT) assessment was done to determine the organization’s readiness for change (See Appendix L). The strengths of the organization are many, including its Magnet and Planetree designation, its mission that highlights the “Patient Experience,” its strong quality ratings, and a Malcolm Baldrige Quality Award designation. Additionally, employee morale is improved based on the most recent employee satisfaction survey from 2017. These things, combined with the dedication of the

nursing staff contribute to the strengths. The recent re-design and construction of a new tower that incorporated elements of patient-centered care are also contributing factors to the organization's strengths.

The weaknesses of the organization are that volumes have exceeded capacity and at times this impacts the quality of care provided. The multiple service lines within the intensive care units create discord among staff, as one provider does not orchestrate the plan of care. The lack of a wide range of experience particularly on the night shift due to union contractual requirements leads to a task-focused care-delivery model when it should be more patient-focused.

There are several strong opportunities and some matching threats as well. Opportunities of the organization are to successfully re-designate as a Planetree organization in 2019. In addition, improving HCAHPS scores, building value-based purchasing power and the shifting from a volume-based model to an experience-based model are all identified opportunities. Common threats for the survival of this organization are recent safety survey scores that indicate staff perceive the organization is not committed to patient safety. Other threats include a culture that is resistant to change. The leadership teams for the frontline staff are very tenured within the organization and recent efforts to implement change by a new director have not been successful.

### **Fiscal Considerations**

The financial budget for this project will be nominal, as outlined in Table 1, except for staff training. The training will be provided during regularly scheduled staff meetings so as not to incur an additional expense that was not budgeted. Approval from the Chief Nursing Officer (CNO) was obtained to provide this training in this venue. Approval was

received from hospital administration to develop and print the posters. Written approval was obtained from the Jean Watson Caring Institute to reproduce the “Watson Caritas Patient Score<sup>®</sup>” for a one-time cost of \$10.00 (see Appendix M).

Table 1

*Cost Itemization*

<b>Item</b>	<b>Cost</b>
Permission for use of the WCPS	\$10.00 one-time fee
Copies of the documents above (400 each)	\$0.00 (in-kind donation)-estimated value \$80.00
2 reams of printer paper	\$0.00 (in-kind donation)-estimated value \$12.00
10 packs Sharpie markers	\$0.00 (in-kind donation)-estimated value \$75.00
Patient Personalization Posters (200 each)	0.00 (in-kind donation)-estimated value \$500.00
Marketing personnel	\$0.00 (in-kind donation)-estimated value 4 hours @\$100.00/hr=\$400.00
Training of 125 staff on poster use	\$0.00 (in-kind donation)-estimated value \$1500.00
Total estimated cost	\$2500.00

Actual cost funded by the DNP student included the one-time fee of \$10.00 to use the WCPS tool. The cost of all other supplies and personnel costs were absorbed by the DNP’s place of employment. There was not a loss of revenue related to this project. Both patients and nursing staff were anticipated to benefit from the use of the posters in terms of both patient and staff

satisfaction. Therefore, the benefits of this project largely outweigh any potential costs, or overhead donated by involved parties.

### **Ethical Considerations**

Ethical approval was obtained following submission of the DNP scholarly project proposal to both the Institutional Review Board of Jacksonville University and the hospital. As mentioned previously, prisoners or those patients in custody by any governmental agency were excluded from the project. Permission to conduct the project was obtained from the Chief Nursing Officer of the organization as well as the Director of Critical Care. The clinical managers of the units where the study was proposed were consulted and approval was granted to use staff huddle time for the training. Prior to approaching relatives of patients to participate in the project, the charge nurse on each unit was engaged. This ensured that relatives who were visiting an imminently dying patient were not approached, thus adhering to the ethical principles of beneficence and non-maleficence.

There was a minimal risk to participants in that the poster may have been inadvertently seen by others not directly involved in the patient's care. This was minimized by placing the poster in a place that was not within view of the patient door. There was not be a need to identify any participant's identity. The data are reported in aggregate. Staff could choose not to participate either in the training or during the intervention. Participation or lack thereof did not influence their performance evaluations or any other employment considerations. Section 164.514 (a) of the Privacy Rule standard to identify the requirements for de-identification of protected health information states that health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used

to identify an individual is not individually identifiable health information (HHS.gov). According to the Department of Health and Human Services (HHS), de-identified health information created following these methods is no longer protected by the privacy rule because it does not fall within the definition of protected health information (PHI). There were no patient confidentiality or HIPAA privacy concerns because all patient identifiers were removed from any data collection tool and patients who are over the age of 89 were aggregated into a single category of 90 or older (HHS.gov). The data that were collected were protected by being stored on the hospital's encrypted server accessed with a unique password only known to the DNP student. For collaboration in the data analysis phase, the team used the JU One Drive and created a shared folder to analyze the aggregate, de-identified data.

### **Project Outcomes**

#### **Statistical Analysis**

A convenience sample of patients admitted to the SICU and the MICU between December 1, 2018 and February 28, 2019, was used for this study. The total number of patients who participated in the project was 199 (102 from the SICU and 97 from the MICU). Of them, 43.7% were females and 54.3% were white. The average (SD) age of participants was 63.1 (17.01). The median length of stay (LOS) in the ICU was 4 days. The percentage of females in the SICU and the MICU were found to be similar (41.2% vs. 46.3%). The number of white patients was 13% higher in the SICU group compared to the MICU (60.8% vs. 47.4%). The descriptive statistics of demographic variables are summarized in Table 2.

Table 2

*Descriptive Statistics of Demographics*

Variables	Surgical ICU (N=102)	Medical ICU (N=97)	Total (N=199)
<b>Sex [n (%)]</b>			
Male	60 (58.8)	51 (53.7)	111 (56.3)
White or Caucasian	62 (60.8)	46 (47.4)	108 (54.3)
Black or African American	6 (5.9)	7 (7.2)	13 (6.5)
Hispanic or Latino	7 (6.9)	7 (7.2)	14 (7.0)
Asian or Asian American	6 (5.9)	13 (13.4)	19 (9.5)
American Indian or Alaska Native	0	0	0
Native Hawaiian or Pacific Islander	0	2 (2.1)	2 (1.0)
n	102	97	199
Mean (SD)	60.6 (16.92)	65.6 (16.81)	63.1 (17.01)
Median	63.5	67.0	64.0
n	102	96	198
Mean (SD)	5.5 (4.79)	5.8 (4.07)	5.7 (4.44)
Median	4.0	4.5	4.0
Patient	33 (32.4)	n/a	33 (32.4)
Family	66 (64.7)	n/a	66 (64.7)
Friend	3 (2.9)	n/a	3 (2.9)

Note: ICU = Intensive Care Unit, n/a = Not applicable, SD = Standard Deviation, Min = Minimum, Max = Maximum,  
% = 100 x (n/N)

“This is My Story” patient personalization poster was implemented in the Surgical ICU

The assessment of nurses' caring behaviors using WCPS instruments is summarized by question and ICU unit in Appendix O. According to the Wilcoxon test results, the average (SD) of WCPS scores was 6.1 (0.85) in the SICU compared to 4.1 (1.01) in the MICU, a difference of 2 in favor of the SICU. The difference was found to be statistically significant using t-test at 5% significance level. WCPS scores were analyzed using a linear regression model adjusting for age, gender, race, and LOS as risk factors. The ICU was included in the model as a fixed factor. The results are summarized in Table 3.

Table 3

*Analysis of WCP Score; Overall Effects of Fixed Factors*

Effect	Numerator DF	Denominator DF	F-Value	P-value	Significant Effect?
Age	1	186	0.05	0.8214	No
LOS	1	186	1.08	0.2999	No
Race	5	186	0.92	0.4704	No
Gender	1	186	0.38	0.5363	No
ICU	1	186	214.30	<.0001	Yes

DF: Degrees of freedom, F: F-test.

“This is My Story” patient personalization poster was implemented in the Surgical ICU  
The analysis was conducted using a linear regression model

As shown in Table 3, none of the patients' characteristics were found to be associated with WCPS scores. The results of F-tests for significant effects showed no evidence of age, gender, race, and LOS (p-values >0.05). Only ICU type was found to have a significant effect on WCPS scores. The comparison between the SICU and the MICU using least-square means (i.e. adjusted means) are summarized in Table 4.

Table 4

*Analysis of WCPS score comparisons between the SICU and the MICU*

ICU	LS Mean	Standard Error	95% Lower	95% Upper	P-value	Significant difference shown?
Surgical	5.9	0.15	5.6	6.2		No
Medical	4.0	0.14	3.7	4.2		No
Difference (Surgical - Medical)	1.9	0.13	1.7	2.2	<.0001	Yes

“This is My Story” patient personalization poster was implemented in the Surgical ICU  
The analysis was conducted using a linear regression model

The adjusted mean difference was 1.9 with 95% confidence interval of (1.7, 2.2). The difference was statistically significant, indicating that the use of patient personalization posters in the SICU has improved patient perceptions of caring practices of their caregivers compared to the MICU (no posters).

In addition, there were improvements in the HCAHPS scores of the SICU receiving units 4W and 6W. Although there were not statistically significant differences in the scores between all of the units, the outcome measure of improving the scores by 5% was demonstrated (Table 5).

Table 5

*Pre/Post Intervention HCAHPS Scores*

	Pre-HCAHPS November 2018	Post-HCAHPS February 2018	Percent Improvement
4W	42	94	123.8%
5W	31	91	193.5%
6W	89	94	5.62%
7W	13	25	92.3%

Of the patients transferred from the SICU, 4W received 38.2% and 6W received 36.2% of transfers, compared with 5W and 7W who each received 5% of the transfers. There is not a clear indication as to why the scores on all of the units improved other than the fact that nurse communication is an organizational priority and there may have been competing projects that contributed to the improved scores. The score on 6W met the threshold of a 5% increase; however, the improvement was only 5.62%. A summary of the scores between the units for February 2019 is included in Appendix D.

Descriptive statistics evaluating the process measure of staff education evaluation pre-implementation are summarized in Appendix P. Overwhelmingly, 100% of staff understood the purpose of the posters and would incorporate them into their daily practice. Descriptive statistics evaluating the post-implementation satisfaction with the posters are summarized in Appendix Q. Overall 70% of staff indicated that they strongly agreed or agreed that the education plan that was provided prior to poster implementation was effective. In addition, there was support for the project post-implementation by staff. The majority of SICU nurses (80%) reported that they strongly agreed or agreed that the posters were instrumental in creating a connection with their patient(s).

### **Final Outcomes**

#### **Outcome Measure: WCPS Scores**

The main goal of this project was to evaluate the relationship between the “This is My Story” poster and the impact on nurses’ caring behaviors. The data supported the PICO question: For adult patients admitted to the surgical intensive care unit (SICU) at an urban community hospital, does use of a “This is My Story” poster, as compared to non-use in the medical

intensive care unit, improve perceptions of caring behaviors as measured by the Watson Caritas Patient Score®? Increases in nurses' perception of caring behaviors were found in SICU on the total WCPS scores as well as on each individual score of the five elements. This project provides evidence that creating a connection with patients/families through the use of a storyboard was a positive intervention. The project demonstrated significant differences in nurses' caring behaviors between the SICU (with posters) and the MICU (without posters) on the total Watson Caritas Patient Score, as well as on each individual question within the Watson Caritas Patient Score tool. Overall the WCPS score in the SICU was improved by 47% compared to that of the MICU.

#### **Outcome Measure: HCAHPS Scores**

The secondary goal of this project was to demonstrate at least a 5% improvement in the HCAHPS scores of the units (7W, 6W, 5W, 4W) that received patients with posters from the SICU. The HCAHPS item that was selected for the analysis was communication with nursing. Communication with nursing correlates with three items on the WCPS scale: meet my basic needs with dignity (Spearman  $\rho = 0.33$ ,  $P < .05$ ), helping and trusting relationships (Spearman  $\rho = 0.36$ ,  $P < .05$ ), and create a caring environment that helps me to heal (Spearman  $\rho = 0.43$ ,  $P < .01$ ) (Brewer & Watson, 2015). Unlike traditional instruments that measure patient satisfaction, the WCPS was designed to measure critical characteristics associated with deep personal human-human connection. The WCPS complements current patient experience measures required by payors and used by many healthcare organizations as well as providing patient feedback to leaders who wish to make improvements in their patient experience metrics. The results of this project did demonstrate a 5% improvement in the scores of all receiving units,

however, there were not any statistically significant differences that could be attributed to the patient personalization posters. One of the units (6W) had the smallest improvement in their score (5.62%) yet had the largest amount of SICU transfers (38.7%).

### **Process Measures**

Pre- and post- implementation process measures were obtained from nursing staff related to their understanding and acceptance of the posters as a way to create a meaningful connection with their patients. The pre-implementation data demonstrated that 100% of nurses responding to the survey would use the posters in their daily practice. This data was important to the project for the culture change that was necessary to create a new environment in which the posters could be used as a means of connection. The post-implementation data also was positive and indicated that the majority of nurses in SICU (80%) agreed or strongly agreed that the posters were helpful in creating a caring connection with their patient. Comments by staff included: “I think the posters are an excellent way of creating the connection with the patients and families! I love them!” and “What a wonderfully simple idea that impacts the patient experience so dramatically!”

### **Limitations**

The most obvious limitation noted initially was the original size of the posters. Working with the marketing department, it was felt that any size larger than 11 x 17 would be too large and likely clutter the patient room. However, this was not the case. The smaller-size poster was lost in the room and the writing on the poster was so small that staff could not engage with the poster as readily as was expected. Marketing was re-engaged after the first week of the intervention and agreed to re-create the poster in a 16 x 20 format. This change completely

altered the dynamic of the interaction between staff and the patient/family. The poster could now be seen from across the room and staff could dialogue with the patient/family in a more casual manner by glancing at the poster upon entering the room or while performing patient-care tasks.

The second limitation noted was the data collection process. Initially it was intended for the bedside nurse to collect the Watson Caritas Patient Score; however, this process was thought by the bedside nursing staff to be biased. They felt that the patient would not answer the survey honestly in their presence, thereby creating a bias in the data. The plan was changed so that the DNP student collected the data on the discharged patients. This resulted in a smaller sample size than was initially anticipated. Additionally, some of the surveys were conducted after the transfer had been completed due to off-hour and weekend transfers.

An additional limitation of this project was that the project was conducted in a single unit of a hospital rather than in multiple units across the health system. There were differences noted in the sample demographics between the SICU and the MICU, most notably the patient age, which could have contributed to the results despite accounting for the variation in the statistical analysis. These could have been mitigated had the project been conducted across either all critical care units within the health system or within all units at the hospital in which the project was implemented. The results may have been biased due to selection bias of the sample; only patients who had completed posters and were willing to complete the WCPS tool were included. Differences in the WCPS between the units could be attributed to other factors not directly related to the interactions of staff with patients/families around the poster.

The improvement in HCAHPS scores could have been attributed to other organizational activities surrounding improved communication that were occurring at the same time as this intervention. The project design did not specifically address any specific intervention targeting the PCU units other than the poster's traveling with the patients to those units. Anecdotally, the managers and staff of the PCU units verbalized that the posters did improve patient satisfaction.

To conclude, the period of this project was limiting. Three months is a short time period, making it difficult to achieve a practice change and determine any trends and outliers in the data. Three months may not be an adequate period to conclude statistical significance. Continuing data collection after the three months to capture more data for validity is ideal.

### **Recommendations for Future Projects**

This project validates that personalizing the patient experience can result in an improved perception of patient care as experienced by the patient/family undergoing a critical illness. As caring continues to come to the forefront as a viable method of impacting patient satisfaction, more studies should be done to evaluate the posters in different settings, such as pediatric, psychiatric, and even community health. Other opportunities are the use of various technologies and whether the differences in technology impact the ability to create a meaningful story that engages staff. In addition, future research could be directed toward front-line nurses and their own perceptions of caring and connections with patients.

### **Implications for Practice**

Watson's (2008) Theory of Human Caring guided this project and the interpretation of the findings. The "This is My Story" intervention helped explicate the caring relationship by demonstrating to patients/families that their story was meaningful to nurses. The posters and the

act of their creation helped facilitate a healing environment and provided extended opportunities for caring–healing connections. Intentionally regarding the patient as an important, dignified other is part of the Theory of Human Caring, and the “This is My Story” intervention was a tangible reminder of that relationship. Press Ganey announced in October 2018 that it had entered into a collaboration with Jean Watson of the Watson Caring Science Institute to offer the Watson Caritas Patient Score (WCPS) as optional questions to Press Ganey clients (Press Ganey, 2018). Press Ganey, along with the Watson Caring Science Institute, will jointly develop research to further understand the connection between caring science and the delivery of safe, high-quality, patient-centered care. The results of this project affirm this new collaborative effort between the two. The nurse–patient relationship has a profound impact on the patient-care experience.

The “This is My Story” poster provided an adjunct to the typical critical care environment, whereby patients/families could communicate the meaningful aspects they wanted to share with their caregivers (Appendix N). It also made it possible to relay these details only once, rather than repeating the same story to multiple people. In addition, the poster was a 24-hour reminder of the patient as a person regardless of their presence in the room, sleeping, or the inability to communicate.

The “This is My Story” intervention was meant to create a connection between the patient and their caregivers, specifically nurses. Communication typically occurs in patient-care settings; however, often it is centered around aspects of a patient’s care plan. The posters facilitated a means to move the level of conversation in a more meaningful direction

leading to an improved perception of caring behaviors. It was found that the posters were therapeutic for not only the patients and their caregivers but also anybody who might touch the patient. Family members learned more about each other and sometimes other staff entering the room, such as food service or housekeeping, would also become engaged in conversation around the poster.

The “This is My Story” intervention is applicable to any health care setting including assisted living, long-term care, hospice, specialty care centers, and home health. Consideration for at-risk populations in the community could also be a setting in which the concept could be utilized, such as the homeless population. Given emerging technologies, the intervention does not need to be limited to a paper poster, but also could be adapted to use electronic media that would convey the same information. However, patients/families who have taken the posters home with them have provided feedback that having the poster at home helped the healing process and provided them with closure around their hospital experience.

### **Dissemination Plans**

This project is being spread across the organization and has been featured as a poster in the lobby of all the entities as a Planetree intervention. In addition, the newly designed guidebook for patients includes a page for the patient’s story. The project will be presented at the New Knowledge and Innovations Conference in San Diego in June 2018 as a podium presentation. A manuscript was written and submitted for consideration in *Critical Care Nurse*. Plans to submit abstracts to both Magnet and the National Teaching Institute (NTI) within the next year are being considered.

Most importantly, the patient's story is now an important part of the culture at our organization. It is an extension of the care that we provide and is just as important as life-saving medications or surgeries. By combining the practices of human caring with our organizational priority of providing the "Patient Experience" to each patient, we are advancing our organization to a new level of nursing excellence.

### **Summary**

One of the most powerful elements in listening to a story is the profound impact it has on the listener. The information gathered from the story is in itself an important element of learning. However, there is another element demonstrated through the change of heart that it encourages in the listener. Patient stories can provide an opportunity to shape the health care of the future. If we embrace the fundamental premise that patients are equal partners in health care, we can work with them to educate our current and future workforce. By educating our workforce, we can equip people with the skills required to work together with patients, to involve them in decisions that affect their lives and have positive outcomes in health care. We live and work in the real world, with all its competing challenges and frustrating setbacks. Sometimes it can be difficult to remember patients are at the core of what we do and are the real reason that nurses exist. Patient stories can inspire us to look at how we can do things differently, which can help us make a positive difference in people's lives, as has been demonstrated with this project.

As a quality improvement project, these data support the evidence of patient personalization posters in improving the perception of nurses' caring behaviors in a critical care environment. Creating opportunities for patients to tell their story is an important area for patient

self-expression and integration of their hospital experience into the whole of their lives. Knowing patients in this more personal way may enable nurses and other team members to advocate more knowledgeably on behalf of patients, thus potentially influencing the quality and safety of patient care.

**References**

- Abraham, M., & Moretz, J. (2012). Implementing patient and family centered care: Part 1: Understanding the challenges. *Pediatric Nursing, 38*(2), 44-47.
- Advisory Board. (2018). *Get to know your patients—not just their charts*. Retrieved from <https://www.advisory.com/research/nursing-executive-center/expert-insights/2012/patient-personalization-posters>
- Agency for Healthcare Research and Quality. (2013). *Information to help hospitals get started*. Retrieved from <https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/howtogetstarted/index.html>
- Alasad, J., & Ahmad, M. (2005). Communication with critically ill patients. *Journal of Advanced Nursing, 50*(4), 356-362.
- Amendolair, D. (2012). Caring behaviors and job satisfaction. *JONA: The Journal of Nursing Administration, 42*(1), 34-39. doi: 10.1097/nna.0b013e31823c18af
- American Hospital Association. (2013). *Engaging healthcare users: A framework for healthy individuals and communities*. Retrieved from [https://www.aha.org/research/cor/content/engaging\\_health\\_care\\_users.pdf](https://www.aha.org/research/cor/content/engaging_health_care_users.pdf)
- Anderson, M., Hall-Lord, M., Wilde-Larson, B., & Persenius, M. (2013). Patient photographs- A landmark for ICU staff: A descriptive study. *Intensive and Critical Care Nursing, 29*, 193-201.

- Bagherian, B., Sabzevari, S., Mirzaei, T., & Ravary, A. (2017). Meaning of caring from critical care nurses perspective: A phenomenological study. *Journal of Intensive and Critical Care, 03(03)*. doi: 10.21767/2471-8505.100092
- Bailey, J. (2011). Does health information technology dehumanize health care? *American Medical Association Journal of Ethics, 13*, 181-185.
- Bailey, J., Sabbagh, M., Loiselle, C., Boileau, J., & McVey, L. (2010). Supporting families in the ICU: A descriptive correlational study of informational support, anxiety, and satisfaction with care. *Intensive and Critical Care Nursing, 26(2)*, 114-122. doi: 10.1016/j.iccn.2009.12.006
- Barrett, F., & Fry, R. (2008). *Appreciative inquiry*. Chagrin Falls (Ohio): Taos Institute Publications.
- Basrai, Z. (2018). Narrative medicine. *Emergency Medicine News, 40*, 1. doi: 10.1097/01.eem.0000534083.21600.cf
- Bastian, B., & Haslam, N. (2011). Experiencing dehumanization: Cognitive and emotional effects of everyday dehumanization. *Basic and Applied Social Psychology, 33*, 295-303.
- Berger, Z., Flickinger, T., Pfoh, E., Martinez, K. & Dy, S. (2014). Promoting engagement by patients and families to reduce adverse events in acute care settings: A systematic review. *British Medical Journal, 23(7)*, 548-555. doi:10.1136/bjwqs-2012-001769.
- Beryl Institute. (2018). Consumer Perspectives on Patient Experience. Retrieved from <https://www.theberylinstitute.org/page/PXCONSUMERSTUDY>.

- Borce, K., & Thorkelsson, R. (2017). What do you know about yours? Patients' stories in critical care. *Canadian Journal of Critical Care Nursing, 28*(2), 62-65.
- Brewer, B., & Watson, J. (2015). Evaluation of Authentic Human Caring Professional Practices. *JONA: The Journal of Nursing Administration, 45*(12), 622-627. doi: 10.1097/nna.0000000000000275
- Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. New York: Penguin Random House.
- Brown, S., Azoulay, E., Benoit, D., Butler, T., Folcarelli, P., Geller, G., ...Howell, M. (2018). The practice of respect in the ICU. *Critical Care Perspective, 197*(11), 1389-1395.
- Cederwall, C., Olausson, S., Rose, L., Naredi, S., & Ringdal, M. (2018). Person-centered care during prolonged weaning from mechanical ventilation, nurses' views: an interview study. *Intensive and Critical Care Nursing 46*(2018), 32-37. doi: 10.1016/j.iccn.2017.11.004
- Charmel, P., & Frampton, S. (2008). Building the business case for patient-centered care. *Healthcare and Financial Management, 62*(3), 80-85. Retrieved from <https://www.planetree.nl/wp-content/uploads/International-HFM-business-case-for-Planetree.pdf>
- Charon, R. (2001). Narrative medicine. *JAMA, 286*(15), 1897. doi: 10.1001/jama.286.15.1897
- Cohn, M. (2018). *ICU patients' outcomes improve when hospital staff also pay attention to families of the sick*. Retrieved from <http://www.baltimoresun.com/health/bs-hs-icu-guidelines-20170130-story.html>

- Cornwell, J. (2017). Exploring how to enable compassionate care in hospital to improve patient experience. *Nursing Times*. Retrieved from <https://www.nursingtimes.net/exploring-how-to-enable-compassionate-care-in-hospital-to-improve-patient-experience/5000526.article>
- Cleary, P. (2016). Evolving concepts of patient-centered care and the assessment of patient care experiences: Optimism and opposition. *Journal of Health Politics, Policy, and Law* 41(4), 675-696. Doi: 10.1215/03616878-362088
- Dabney, B., & Tzenh, H. (2013). Service quality and patient-centered care. *MEDSURG Nursing*, 22(6), 359-364.
- Dossey, B., Keegan, L., & Barrere, C. (2016). *Holistic nursing*. Burlington: Jones & Bartlett.
- Eckman, E., & Krasner, M. (2016). Empathy in medicine: Neuroscience, education and challenges. *Medical Teacher*, 39(2), 164-173. Retrieved from <http://dx.doi.org/10.1080/0142159x.2016.1248925>
- Elliott, G., Kao, S., & Grant, N. (2004). Mattering: Empirical validation of a social-psychological safety. *Self-Identity* 3(4), 339-354.
- Facioli, A., Amorim, F., & Almeida, K. (2012). A model for humanization in critical care. *The Permanente Journal*, 16(4), 75-77. doi: 10.7812/tpp/12-044
- Fenton, J., Jerant, A., Bertakis, K., & Franks, P. (2012). The cost of satisfaction: A national study of patient satisfaction, health care utilization, expenditures, and mortality. *Archives of Internal Medicine*, 172(5), 405-411. doi:10.1001/archinternmed.2011.1662
- Finfgeld-Connett, D. (2008). Concept synthesis of the art of nursing. *Journal of Advanced Nursing*, 62(3), 381-388. Doi: 10.1111/j.1365-2648.2008.04601

- Fontaine, D., Haizlip, J., & Lavandero, R. (2018). No time to be nice in the intensive care unit. *American Journal of Critical Care, 27*(2), 153-156. [https://doi: 10.4037/ajcc2018401](https://doi.org/10.4037/ajcc2018401)
- Glebocki, M., & Dunn, K. (2010). Building an organizational culture of caring: Caring perceptions enhanced with education. *The Journal of Continuing Education in Nursing, 41*(12), 565-570. doi:10.3928/00220124-20100701-05
- Goncalves, S., Strong, L., & Nelson, M. (2016). Measuring nurse caring behaviors in the hospitalized older adult. *JONA: The Journal of Nursing Administration, 46*(3), 132-138. doi:10.1097/nna.0000000000000312
- Grob, R. (2013). The heart of patient-centered care. *The Journal of Health Politics, Policy and Law, 38*(2), 457-464. doi:10.1215/03616878-1966406
- Groene, O. (2011). Patient centeredness and quality improvement efforts in hospitals: Rationale, measurement, implementation. *International Journal for Quality in Health Care, 23*(5), 531-537. doi: 10.1093/intqhc/mzr058
- Hakanson, C., & Ohlen, J. (2014). Connectedness at the end of life among people admitted to inpatient palliative care. *American Journal of Hospice and Palliative Medicine, 33*(1), 47-54. doi: 10.1177/1049909114554077
- Haley, B., Heo, S., Wright, P., Barone, C., Rao Rettiganti, M., & Anders, M. (2017). Relationships among active listening, self-awareness, empathy, and patient-centered care in associate and baccalaureate degree nursing students. *Nursingplus Open, 3*, 11-16. doi: 10.1016/j.npls.2017.05.001
- Halpern, J. (2003). What is clinical empathy? *Journal of General Internal Medicine, 18*(8), 670-674. doi: 10.1046/j.1525-1497.2003.21017.

Haque, O., & Waytz, A. (2012). Dehumanization in medicine: Causes, solutions, and functions.

*Perspectives on Psychological Science*, 7, 176-186.

Hardicre, J. (2003). Meeting the needs of families of patients in intensive care units. *Nursing*

*Times* 99(27), 26-27.

Havens, D., Wood, S., & Leeman, J. (2006). Improving nursing practice and patient care. *JONA:*

*The Journal of Nursing Administration*, 36(10), 463-470. doi: 10.1097/00005110-

200610000-00007

Hobbs, J. (2009). A dimensional analysis of patient-centered care. *Nursing Research*, 58(1), 52-

62. doi: 10.1097/nnr.0b013e31818c3e79

Institute for Patient and Family-Centered Care. (2010). *Frequently asked questions*. Retrieved

from <https://www.ipfcc.org/faq.html>

Institute of Medicine. (2000). *To err is human: Building a safer health system*. Washington,

D.C.: National Academic Press.

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st*

*Century*. Washington: National Academic Press.

Institute of Medicine. (2004). *Keeping Patients Safe: Transforming the Work Environment of*

*Nurses*. Washington: National Academic Press.

Jha, A., Orav, E., Zheng, J., & Epstein, A. (2008). Patients' perception of hospital care in the

United States. *New England Journal of Medicine*, 359(18), 1921-1931.

doi: 10.1056/NEJMsa0804116

Koloroutis, M., Felgen, J., & Wessel, S. (2007). *Relationship-based care*. Minneapolis, MN:

Creative Health Care Management.

- Kutney-Lee, A., McHugh, M., Sloane, D., Cimiotti, J., Flynn, L., Neff, D., & Aiken, L. (2009). Nursing: A key to patient satisfaction. *Health Affairs*, 28(4), W669-W677.  
doi: 10.1377/hlthaff.28.4.w669
- Leininger, M. & McFarland, M. (2006). *Culture are diversity and universality*. Sudbury, MA: Jones and Bartlett.
- Loghmani, L., Borhani, F., & Abbaszadeh, A. (2014). Factors affecting the Nurse-Patients' family communication in intensive care unit of Kerman: A qualitative study. *Journal of Caring Science*, 3(1), 67-82.
- Luxford, K., Safran, D., & Delbanco, T. (2011). Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *International Journal for Quality in Health Care*, 23(5), 510-515. Doi: 10.1093/intqhc/mzr024
- Lotfy Abdel-Aziz, A. (2017). Family needs of critically ill patients admitted to the intensive care unit, comparison of nurses and family perception. *American Journal of Nursing Science*, 6(4), 333. doi: 10.11648/j.ajns.20170604.18
- MacDavitt, K., cieplinski, J., & Walker, V. (2011). Implementing small tests of change to improve patient satisfaction. *JONA: The Journal of Nursing Administration*, 41(1), 5-9.  
Doi: 10.1097/nna.0b013e318200285b
- Makic, M. (2017). Critical care connection nurses' caring behaviors. *Journal of Perianesthesia Nursing*, 32(4), 367-369. doi: 10.1016/j.jopan.2017.05.006
- Manary, M., Boulding, W., & Staelin, R. (2013). The patient experience and health outcomes. *The New England Journal of Medicine*, 368, 201-203.

- Manary, M., Staelin, R., Kosel, K., Schulman, K., & Glickman, S. (2015). Organizational characteristics and patient experience with hospital care: A survey study of hospital chief patient experience officers. *American Journal of Medical Quality, 30*(5), 432-440. doi:10.1177/1062860614539994
- Mathad, M., Pradhan, B., & Rajesh, S. (2017). Correlates and predictors of resilience among baccalaureate nursing students. *Journal of Clinical and Diagnostic Research, 11*(2), JC05-JC08. doi: 10.7860/JCDR/2017/24442.9352
- McGrath, M. (2008). The challenges of caring in a technological environment: Critical care nurses' experiences. *Journal of Clinical Nursing, 17*(8), 1096-1104. Doi: 10.1111/j.1365-2702.2007.02050
- Medvedev, O., & Landhuis, C. (2018). Exploring constructs of well-being, happiness and quality of life. *Peerj, 6*. doi: 10.7717/peerj.4903
- Melia, K. (2013). When the body is past fixing: caring for bodies, caring for people. *Journal of Clinical Nursing, 23*(5-6), 616-622. doi: 10.1111/jocn.12380
- Melnyk, B., & Fineout-Overholt, E. (2015). *Evidence-based practice in nursing and healthcare*. Philadelphia, PA: Wolters Kluwer/Lippincott Williams.
- Miner-Williams, D. (2005). Connectedness in the nurse-patient relationship: A grounded theory study. *Issues in Mental Health Nursing, 28*(11), 1215-1234. doi: 10.1080/01612840701651462
- Mitchell, J. (2007). Enhancing patient connectedness: Understanding the nurse-patient relationship. *International Journal for Human Caring, 11*(4), 79-82.

- Modic, M., Siedlecki, S., Griffin, M., & Fitzpatrick, J. (2016). Caring behaviors: Perceptions of acute-care nurses and hospitalized patients with diabetes. *International Journal for Human Caring*, 20(3), 160-164. doi: 10.20467/1091-5710-20.3.160
- Moghaddasian, S., Dizaji, S., & Mahmoudi, M. (2013). Nurses' empathy and family needs in the intensive care units. *Journal of Caring Sciences*, 2(3), 197-201.
- Moorer, K., Kunupakaphun, S., Delgado, E., Moody, M., Wolf, C., Moore, K., & Eamranond, P. (2017). Using appreciative inquiry as a framework to enhance the patient experience. *Patient Experience Journal*, 4(3), 128-135.
- Moran, K., Burson, R., & Conrad, D. (2014). *The doctor of nursing practice project*. New York: Jones & Bartlett
- Munger, A., Rios, Y., Ignowski, C., Nelson, M., Gass, S., & Festa, C. (2012). Communicating with the unresponsive patient. *Dimensions of Critical Care Nursing*, 31(5), 275-282. doi: 10.1097/dcc.0b013e3182619968
- Natale, C., & Gross, D. (2013). The ROI of engaged patients. *Healthcare Financial Management*, 67(8), 90-97.
- Nelson, J., Puntillo, K., Pronovost, P., Walker, A., McAdam, J., Ilaoa, D., & Penrod, J. (2010). In their own words: Patients and families define high-quality palliative care in the intensive care unit. *Critical Care Medicine*, 38(3), 808-818. doi: 10.1097/ccm.0b013e3181c5887c
- Northouse, P. (2016). *Leadership Theory and Practice*. Thousand Oaks, CA: Sage Publication.
- Nursing Research (2017). Retrieved from <https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/nursing-research/>

- Nussbaum, G. (2003). Spirituality in critical care: Patient comfort and satisfaction. *Critical Care Nursing Quarterly*, 26(3), 214-220. doi: 10.1097/00002727-200307000-00006
- Peigne, V., Chaize, M., Falissard, B., Kentish-Barnes, N., Rusinova, K., & Megarbane, B. (2011). Important questions asked by family members of intensive care unit patients. *Critical Care Medicine*, 39(6), 1365-1371. doi: 10.1097/ccm.0b013e3182120b68
- Pipe, T., Kelly, A., LeBrun, G., Smidt, D., Atherton, P., & Robinson, C. (2008). A prospective descriptive study exploring hope, spiritual well-being, and quality of life in hospitalized patients. *Medsurg Nursing*, 17, 247-253.
- Pipe, T., Mishark, K., Hansen, R., Hentz, J., & Hartsell, Z. (2010). Rediscovering the art of healing connection by creating the tree of life poster. *Journal of Gerontological Nursing*, 36(6), 47-55. doi: 10.3928/00989134-20100330-04
- Planetree. (2018). *Home*. Retrieved from <https://planetree.org/>.
- Prey, J., Woollen, J., Wilcox, L., Sackeim, A., Hripcsak, G., ... Vawfrey, D. (2014). Patient engagement in the inpatient setting: A systematic review. *Journal of the American Medical Informatics Association*, 21(4), 742-750. doi: 10.1136/amiajni-2013-002141
- Reis, C., Sena, E., & Fernandes, M. (2016). Humanization care in intensive care units: Integrative review. *Journal of Research Fundamental Care Online*, 8(2), 4212-4222. doi:10.9789/2175-5361.2016.v8i2.4212-4222
- Sacco, T., Cieurzynski, S., Harvey, M., & Ingersoll, G. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse*, 35(4), 32-42. doi: 10.4037/ccn2015392

- Shalaby, S., Janbi, N., Mohammed, K., & Al-harathi, K. (2018). Assessing the caring behaviors of critical care nurses. *Journal of Nursing Education and Practice*, 8(10), 77.  
doi: 10.5430/jnep.v8n10p77
- Shorifi, S., Jannati, Y., Moghaddam, H., & Yazdani-Charati, J. (2016). Psychosocial needs of families of intensive care patients: perceptions of nurses and families. *Nigerian Medical Journal* 57(1), 10-18. doi: 10.4103/0300-1652.180557
- Small, N., Green, J., Spink, J., Forster, A., Lowson, K., & Young, J. (2008). The patient experience of community hospital: The process of care as a determinant of satisfaction. *Journal of Evaluation in Clinical Practice*, 13(1), 95-101.  
doi:10.1111/j.1365-2753.2006.00653.
- Tunlind, A., Granström, J., & Engström, Å. (2015). Nursing care in a high-technological environment: Experiences of critical care nurses. *Intensive and Critical Care Nursing*, 31(2), 116-123. doi: 10.1016/j.iccn.2014.07.005
- Springer Science + Business Media B.V. (2011). *Humiliation, Degradation, Dehumanization*
- Turner, Y., & Hadas-Halpern, I. (2008). *The effects of including a patient photograph to the radiographic examination*. Paper presented at the Radiological Society of North American 2008 Scientific Assembly and Annual meeting, Chicago, IL. Retrieved from <https://archive.rsna.org/2008/6008880.html>
- Vaes, J., & Muratore, M. (2013). Defensive dehumanization in the medical practice: A cross-sectional study from a health care worker's perspective. *British Journal of Social Psychology* 52, 180-190. doi:10.1111/bjso.12008

- Van Gorder, C. (2015). *The front-line leader*. San Francisco: Jossey-Bass.
- Vedotto, D., & Silva, R. (2011). Humanization with the family in an intensive care unit: A descriptive study. *Brazilian Journal of Nursing*, 9(3). Retrieved from <https://www.objnursing.uff.br/index.php/nursing/article/view/j.1676-4285.2010.3135>
- Villanueva, N. (1999). Experiences of critical care nurses caring for unresponsive patients. *Journal of Neuroscience Nursing*, 31(4), 216-223. doi:10.1097/01376517-199908000-00003
- Watkins, S., Dewar, B., & Kennedy, C. (2016). Appreciative Inquiry as an intervention to change nursing practice in in-patient settings: An integrative review. *International Journal of Nursing Studies*, 60, 179-190. doi: 10.1016/j.ijnurstu.2016.04.017
- Watson, J. (2009). *Assessing and measuring caring in nursing and health sciences*. New York, NY: Springer Publishing.
- Watson, J. (2012). *Human caring science*. Sudbury, MA: Jones & Bartlett Learning.
- Watson, J., & Brewer, B. (2015). Caring science research: Criteria, evidence, and measurement. *JONA: Journal of Nursing Administration*, 45(5), 235-236.  
doi: 10.1097/NNA.0000000000000190
- Weaver, J., Bradley, C., & Brasel, K. (2012). Family engagement regarding the critically ill patient. *Surgical Clinics of North America*, 92(6), 1637-1647.  
doi: 10.1016/j.suc.2012.08.004

Weyant, R., Clukey, L., Roberts, M., & Henderson, A. (2017). Show your stuff and watch your

tone: Nurses' caring behaviors. *American Journal of Critical Care*, 26(2), 111-117.

doi: 10.4037/ajcc2017462

What is Appreciative Inquiry (AI)?. The Center for APPRECIATIVE INQUIRY. (2019).

Retrieved from <https://www.centerforappreciativeinquiry.net/more-on-ai/what-is-appreciative-inquiry-ai/>

Wilkin, K., & Slevin, E. (2004). The meaning of caring to nurses: an investigation into the nature

of caring work in an intensive care unit. *Journal of Clinical Nursing* 13(1), 651-659.

Wolf, J., Niederhouser, V., Marshburn, D., & LaVela, S. (2014). Defining patient experience.

*Patient Experience Journal* 1(1), 7-19.

Zimlichman, E., Rozenblum, R., & Millenson, M. (2013). The road to patient experience of care

measurement: Lessons from the United States. *Israel Journal of Health Policy Research*,

2(1), 35-41.

Appendix A: Assessment of Readiness for Plane tree Re-designation

Readiness Score for Criterion 4.3.		3.50
4.4. Systems are in place to document and honor, to the extent possible, patients'/residents' preferences related to: <ul style="list-style-type: none"> <li>• Activities of daily living (meals, bathing, grooming, sleep)</li> <li>• Scheduling and access</li> <li>• Cultural norms and spiritual beliefs</li> <li>• Use/interest in a broad range of healing modalities, including those considered complementary to Western or traditional modalities</li> <li>• Their personal environment</li> <li>• Positive diversions and/or life enrichment activities (including social support)</li> </ul>		
Measurable Elements*		
For this criterion, the number of "preference domains" e.g. meals and mealtime, sleep, scheduling and access, etc. that a site must be equipped to accommodate varies based on the setting of care: <ul style="list-style-type: none"> <li>• In residential settings, a minimum of 6 must be addressed</li> <li>• In acute care settings, a minimum of 4 must be addressed</li> <li>• In ambulatory settings, a minimum of 2 must be addressed.</li> </ul>		Point Value
4.4.1a. Mechanisms are in place to accommodate personal preferences related to meals and mealtime.	8	Completely
4.4.1b. Mechanisms are in place to accommodate personal preferences related to sleep (e.g. routines, wake times, etc.).		Partially
4.4.1c. Mechanisms are in place to accommodate personal preferences related to bathing and personal grooming.		Partially
4.4.1d. Mechanisms are in place to accommodate personal preferences related to scheduling and access.		Partially
4.4.1e. Mechanisms are in place to accommodate personal preferences related to use of a broad range of healing modalities, including those considered complementary to Western or traditional modalities.		Completely
4.4.1f. Mechanisms are in place to accommodate personal preferences related to their personal environment.		Completely
4.4.1g. Mechanisms are in place to accommodate personal preferences related to positive diversions and/or life enrichment activities (including social support).		Partially
4.4.2. Mechanisms are in place to integrate individuals' spiritual beliefs and cultural norms into their care and treatment upon request.	1	Partially

Appendix B: Johns Hopkins Nursing Evidence Table

Evidence Levels	Quality Guides
<b>Level I</b> Experimental study, randomized controlled trial (RCT) Systematic review of RCTs, with or without meta-analysis	<b>A High quality:</b> Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence  <b>B Good quality:</b> Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence  <b>C Low quality or major flaws:</b> Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn
<b>Level II</b> Quasi-experimental study Systematic review of a combination of RCTs and quasi-experimental, or quasi-experimental studies only, with or without meta-analysis	
<b>Level III</b> Non-experimental study Systematic review of a combination of RCTs, quasi-experimental and non-experimental studies, or non-experimental studies only, with or without meta-analysis Qualitative study or systematic review with or without a meta-synthesis	

Evidence Levels	Quality Guides
<b>Level IV</b> Opinion of respected authorities and/or nationally recognized expert committees/consensus panels based on scientific evidence  Includes: <ul style="list-style-type: none"> <li>• Clinical practice guidelines</li> <li>• Consensus panels</li> </ul>	<b>A High quality:</b> Material officially sponsored by a professional, public, private organization, or government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years  <b>B Good quality:</b> Material officially sponsored by a professional, public, private organization, or government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years  <b>C Low quality or major flaws:</b> Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies; insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the last 5 years

<b>Level V</b> Based on experiential and non-research evidence  Includes: <ul style="list-style-type: none"> <li>• Literature reviews</li> <li>• Quality improvement, program or financial evaluation</li> <li>• Case reports</li> <li>• Opinion of nationally recognized experts(s) based on experiential evidence</li> </ul>	<b>Organizational Experience:</b> <b>A High quality:</b> Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial or program evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence  <b>B Good quality:</b> Clear aims and objectives; consistent results in a single setting; formal quality improvement or financial or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence  <b>C Low quality or major flaws:</b> Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement, financial or program evaluation methods; recommendations cannot be made  <b>Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference:</b> <b>A High quality:</b> Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader(s) in the field  <b>B Good quality:</b> Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions  <b>C Low quality or major flaws:</b> Expertise is not discernable or is dubious; conclusions cannot be drawn
---	--

(The John Hopkins Hospital; Johns Hopkins University School of Nursing, 2017)

Appendix C: Sample Press Ganey Survey (HCAHPS)

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>VISITORS AND FAMILY</b>					
1. Accommodations and comfort for visitors .....	<input type="radio"/>				
2. Staff attitude toward your visitors .....	<input type="radio"/>				
Comments (describe good or bad experience): _____					

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>PHYSICIAN</b>					
1. Time physician spent with you .....	<input type="radio"/>				
2. Physician's concern for your questions and worries .....	<input type="radio"/>				
3. Skill of the physician .....	<input type="radio"/>				
Comments (describe good or bad experience): _____					

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>DISCHARGE</b>					
1. Extent to which you felt ready to be discharged .....	<input type="radio"/>				
2. Speed of discharge process after you were told you could go home .....	<input type="radio"/>				
3. Instructions given about how to care for yourself at home .....	<input type="radio"/>				
Comments (describe good or bad experience): _____					

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>PERSONAL ISSUES</b>					
1. Staff concern for your privacy .....	<input type="radio"/>				
2. Degree to which hospital staff addressed your emotional needs .....	<input type="radio"/>				
3. Response to concerns/complaints made during your stay .....	<input type="radio"/>				
4. Staff effort to include you in decisions about your treatment .....	<input type="radio"/>				
Comments (describe good or bad experience): _____					

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>OVERALL ASSESSMENT</b>					
1. How well staff worked together to care for you .....	<input type="radio"/>				
2. Overall rating of care given at hospital .....	<input type="radio"/>				
3. Likelihood of your recommending this hospital to others .....	<input type="radio"/>				
Comments (describe good or bad experience): _____					

Patient's Name: (optional) \_\_\_\_\_

Telephone Number: (optional) \_\_\_\_\_



**THANK YOU**  
Please return the completed survey in the postage-paid envelope.



© 2004 PRESS GANEY ASSOCIATES, INC.  
All Rights Reserved  
C146000X-12000X-001-0008

This survey was current at the time of printing and distribution to you.  
If you would like to confirm that it is still the most recent version, please contact your Consultant or Account Executive.

15. During this hospital stay, were you given any medicine that you had not taken before?

- Yes
No If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

- Never
Sometimes
Usually
Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

- Never
Sometimes
Usually
Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

- Own home
Someone else's home
Another health facility

If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

- Yes
No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

- Yes
No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover. Do not include any other hospital stay in your answers.

21. 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?

- 0 Worst hospital possible
1
2
3
4
5
6
7
8
9
10 Best hospital possible



22. Would you recommend this hospital to your friends and family?

- Definitely no
Probably no
Probably yes
Definitely yes

ABOUT YOU

23. In general, how would you rate your overall health?

- Excellent
Vary Good
Good
Fair
Poor

24. What is the highest grade or level of school that you have completed?

- 8th grade or less
Some high school, but did not graduate
High school graduate or GED
Some college or 2-year degree
4-year college graduate
More than 4-year college degree

25. Are you of Spanish, Hispanic or Latino origin or descent?

- No, not Spanish/Hispanic/Latino
Yes, Puerto Rican
Yes, Mexican, Mexican American, Chicano
Yes, Cuban
Yes, other Spanish/Hispanic/Latino

26. What is your race? Please choose one or more.

- White
Black or African American
Asian
Native Hawaiian or other Pacific Islander
American Indian or Alaska Native

27. What language do you mainly speak at home?

- English
Spanish
Some other language (please print):

**ADDITIONAL QUESTIONS ABOUT YOUR STAY**

Now that we have asked you to tell us about what happened during your stay, we want to ask you about how well we met your needs.

**INSTRUCTIONS:** Please rate the services you received from our facility. Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>ADMISSION</b>					
1. Speed of admission process .....	<input type="radio"/>				
2. Courtesy of the person who admitted you .....	<input type="radio"/>				

Comments (describe good or bad experience): \_\_\_\_\_

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>ROOM</b>					
1. Pleasantness of room decor .....	<input type="radio"/>				
2. Courtesy of the person who cleaned your room .....	<input type="radio"/>				
3. Room temperature .....	<input type="radio"/>				

Comments (describe good or bad experience): \_\_\_\_\_

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>MEALS</b>					
1. Temperature of the food (cold foods cold, hot foods hot) .....	<input type="radio"/>				
2. Quality of the food .....	<input type="radio"/>				
3. Courtesy of the person who served your food .....	<input type="radio"/>				

Comments (describe good or bad experience): \_\_\_\_\_

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>NURSES</b>					
1. Nurses' attitude toward your requests .....	<input type="radio"/>				
2. Amount of attention paid to your special or personal needs .....	<input type="radio"/>				
3. Skill of nurses .....	<input type="radio"/>				

Comments (describe good or bad experience): \_\_\_\_\_

	very poor 1	poor 2	fair 3	good 4	very good 5
<b>TESTS AND TREATMENTS</b>					
1. Waiting time for tests or treatments .....	<input type="radio"/>				
2. Explanations about what would happen during tests or treatments .....	<input type="radio"/>				
3. Courtesy of the person who took your blood .....	<input type="radio"/>				
4. Courtesy of the person who started the IV .....	<input type="radio"/>				

Comments (describe good or bad experience): \_\_\_\_\_

(continued...)

# CLIENT LOG

Hospital CAHPS®

OMB Control Number: 0938-0981

**SURVEY INSTRUCTIONS:** You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all the questions by filling in the circle to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next.

Please answer the questions in this survey about this stay at (Hospital Name). Do not include any other hospital stay in your answers.

Please use black or blue ink to fill in the circles completely.  
Example: ●

### YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?  
 Never  
 Sometimes  
 Usually  
 Always
2. During this hospital stay, how often did nurses listen carefully to you?  
 Never  
 Sometimes  
 Usually  
 Always
3. During this hospital stay, how often did nurses explain things in a way you could understand?  
 Never  
 Sometimes  
 Usually  
 Always
4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?  
 Never  
 Sometimes  
 Usually  
 Always  
 I never pressed the call button

### YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?  
 Never  
 Sometimes  
 Usually  
 Always
6. During this hospital stay, how often did doctors listen carefully to you?  
 Never  
 Sometimes  
 Usually  
 Always
7. During this hospital stay, how often did doctors explain things in a way you could understand?  
 Never  
 Sometimes  
 Usually  
 Always

### THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?  
 Never  
 Sometimes  
 Usually  
 Always
9. During this hospital stay, how often was the area around your room quiet at night?  
 Never  
 Sometimes  
 Usually  
 Always

### YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?  
 Yes  
 No     If No, Go to Question 12
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?  
 Never  
 Sometimes  
 Usually  
 Always
12. During this hospital stay, did you need medicine for pain?  
 Yes  
 No     If No, Go to Question 15
13. During this hospital stay, how often was your pain well controlled?  
 Never  
 Sometimes  
 Usually  
 Always
14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?  
 Never  
 Sometimes  
 Usually  
 Always

(continued...)

Appendix D: Progressive Care Unit HCAHPS scores

November 2018 (7 West, 6 West, 5 West, 4 West)



		1 West	3 North	4 West	4 North	5 West	5 North	6 West	6 North	7 West	Total
<b>Indicator</b>	<b>SHC</b>	<b>SMH top box</b>									
	<b>n</b>	7	20	40	41	21	20	44	64	31	294
	<b>Goal</b>	<b>Rank</b>									
Nurses always communicated well	90%	99	33	42	14	31	96	89	97	13	67

February 2019 Progressive Care Unit HCAHPS scores

(7 West, 6 West, 5 West, 4 West)



		1 West	3 North	4 West	4 North	5 West	5 North	6 West	6 North	7 West	Total
<b>Indicator</b>	<b>SHC</b>	<b>SMH top box</b>									
	<b>n</b>	14	36	48	58	32	38	61	73	47	415
	<b>Goal</b>	<b>Rank</b>									
Nurses always communicated well	90%	99	94	94	95	91	87	94	94	25	91

Appendix E: Sample Poster

## This Is My Story

We want to get to know you — and understand what's important to you — so we can better support and care for you throughout your stay.

Tell us about yourself by filling out this form. Include as much detail as you'd like to share. Your friends and loved ones can help, too. If you need any assistance, please ask your nurse.

**NAME**

**I PREFER TO BE CALLED**

**OCCUPATION**

**IMPORTANT PEOPLE IN MY LIFE**

**FAVORITES**

Movie	TV Show	Book	Music	Sport
Color	Food	Pets	Guide/Seeing	

**ACTIVITIES/HOBBIES**

**ACHIEVEMENTS I AM PROUD OF**

**THINGS THAT CHEER ME UP**

**OTHER THINGS I'D LIKE YOU TO KNOW ABOUT ME**

**AT HOME I USE**

Glasses  
  Contact Lenses  
  Hearing Aids  
  Dentures  
  Other \_\_\_\_\_

© 2014 Sharp Corporation

Appendix F: Educational Flyer

This is My Story Project

We want you to get to know your patient!

These storyboards will be in the SICU and will travel with the patient as they transfer to other units and eventually home. The poster allows family members and other visitors to share information that helps us know our patients "story". The posters will be 16 x 20 and will be located on a wall in the patient's room. Please use them to find out an interesting fact about the patient to engage them in a meaningful conversation!

If you have questions or concerns about this project, please contact: Kelly Johnson, SICU Manager at 858-939-5928 or [kelly.johnson@gmail.com](mailto:kelly.johnson@gmail.com)

**This Is My Story**

We want to get to know you – and understand what's important to you – so we can better support and care for you throughout your stay.

Tell us about yourself by filling out this form. Include as much detail as you'd like to share. Your friends and loved ones can help, too. If you need any assistance, please ask your nurse.

**NAME**

**I PREFER TO BE CALLED**  **IMPORTANT PEOPLE IN MY LIFE**

**OCCUPATION**

**FAVORITES**

Movie	TV Show	Book	Music	Sport
Color	Foods	Pets	Quota/Saying	

**ACTIVITIES/HOBBIES**

**ACHIEVEMENTS I AM PROUD OF**

**THINGS THAT CHEER ME UP**

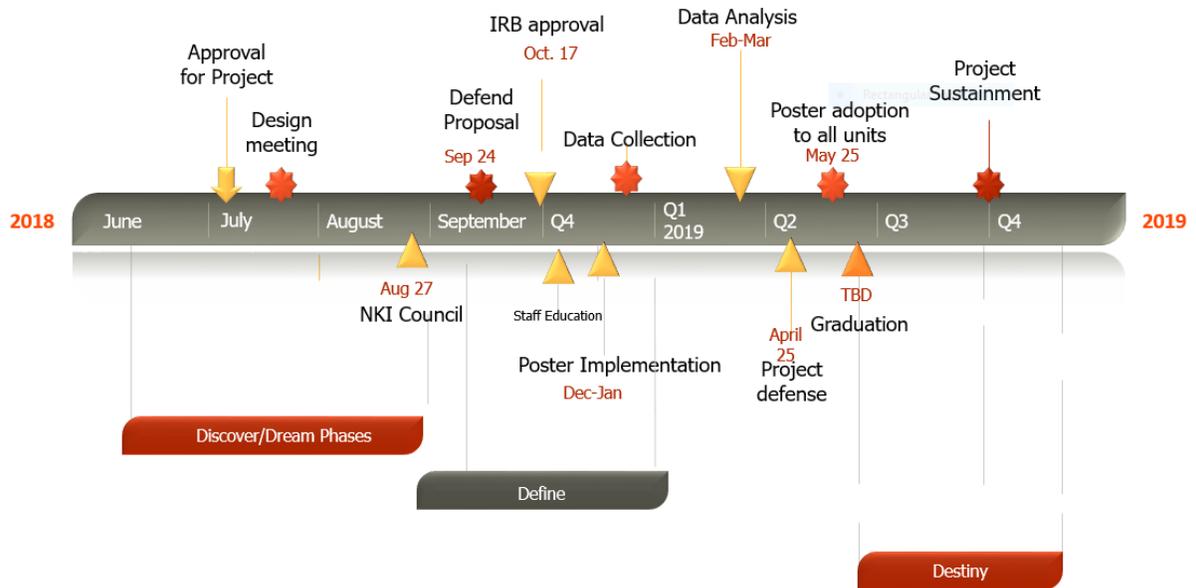
**OTHER THINGS I'D LIKE YOU TO KNOW ABOUT ME**

**AT HOME I USE**

Glasses  Contact Lenses  Hearing Aids  Dentures  Other

Appendix G: Timeline

# This is My Story Project Timeline



Appendix H: WCPS Tool

Watson Caritas Patient Score<sup>®</sup>

WCPS ver. 2.0



Watson Caritas Patient Score<sup>®</sup>

**DIRECTIONS:** When answering the questions, please consider the overall consistency of human-to-human CARE you have received **during this hospital stay**. Please circle the number for the one best answer.

My caregivers:	Never						Always
Deliver my care with loving-kindness.	1	2	3	4	5	6	7
Meet my basic human needs with dignity.	1	2	3	4	5	6	7
Have helping and trusting relationships with me.	1	2	3	4	5	6	7
Create a caring environment that helps me to heal.	1	2	3	4	5	6	7
Value my personal beliefs and faith, allowing for hope.	1	2	3	4	5	6	7

We invite you to share any notable caring or uncaring moments you experienced during this hospital stay.

Thank you for completing our questionnaire!

Watson, J., Brewer, B.B., & D'Alfonso, J. (2014). *Watson Caritas Patient Score (WCPS)*. © Watson Caring Science Institute: Boulder, CO. [www.watsoncaringscience.org](http://www.watsoncaringscience.org)

What is your relationship to the patient?

Subject ID:

\_\_\_\_\_

Appendix I: Data Collection Tool

Data Collection Tool

Subject ID:

**Subject ID will be a random number assigned to each tool that coincides with the WCPS Subject ID**

1. ICU Location of patient admitted

SICU

MICU

2. Patient's Race

White or Caucasian

Black or African American

Hispanic or Latino

Asian or Asian American

American Indian or Alaska Native

Native Hawaiian or other Pacific Islander

Another race

3. Gender

Male

Female

4. Diagnosis

5. Age

6. What Unit did patient transfer to?

7W

6W

5W

4W

Acute Care Unit

External facility

7. Did patient poster go with patient at transfer?

Yes

No

8. Length of ICU stay in days

Appendix J: Staff Education Evaluation Tool

**"This is My Story" Education Satisfaction Survey**

**Please answer these two questions to evaluate the education you received about the implementation of patient personalization posters in the SICU.**

1. The "This is My Story" educational presentation increased my understanding of the use of patient personalization posters?

Strongly agree  Disagree

Agree  Strongly disagree

Neither agree nor disagree

2. I will use the patient personalization posters: "This is My Story" when caring for my patients/families.

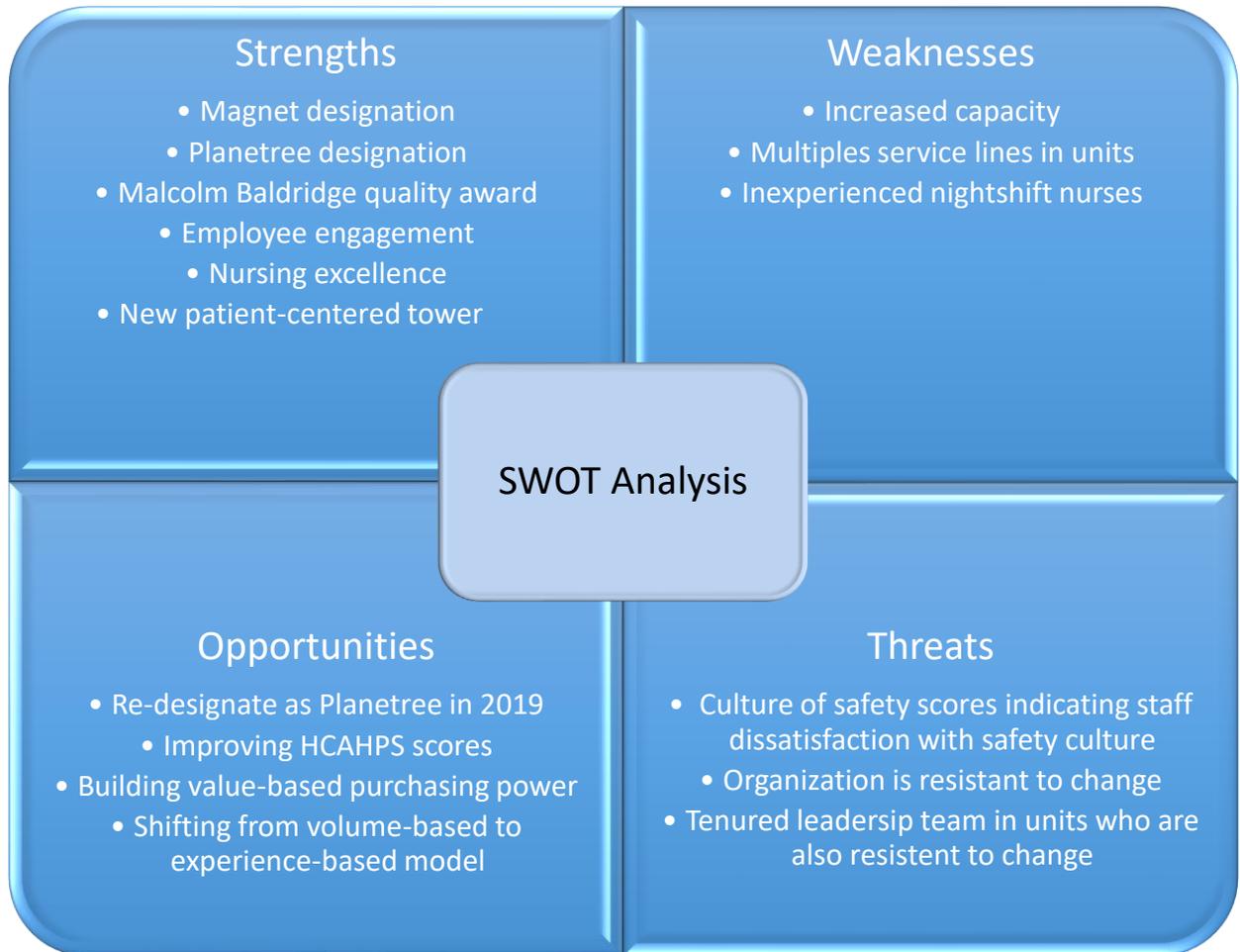
Very likely  Unlikely

Likely  Very unlikely

Neither likely nor unlikely



Appendix L: SWOT Analysis



## Appendix M: Written permission to use Watson Patient Caritas tool

---

**From:** Jean <[jeanwatson@comcast.net](mailto:jeanwatson@comcast.net)>  
**Sent:** Wednesday, June 20, 2018 09:10 AM  
**To:** Kelly Johnson <[Kelly.Johnson@sharp.com](mailto:Kelly.Johnson@sharp.com)>  
**Cc:** Katie Small <[katie@asmallbizsolution.com](mailto:katie@asmallbizsolution.com)>; Carol Wadsworth <[carol@beezdezines.com](mailto:carol@beezdezines.com)>; Julie Watson <[julie@watsoncaringscience.org](mailto:julie@watsoncaringscience.org)>; Barbara Brewer <[bbrewer@email.arizona.edu](mailto:bbrewer@email.arizona.edu)>  
**Subject:** Use of research instrument fee

[EXTERNAL SENDER]

Kelly hi and thanks for your interest in the use of the instrument for your research.

It is a fee one time to download and access for use. It is not based upon number of times used per participant/subject.

I hope this is helpful.

All good wishes with your research . Please let us know how it goes.

In loving kindness, Jean

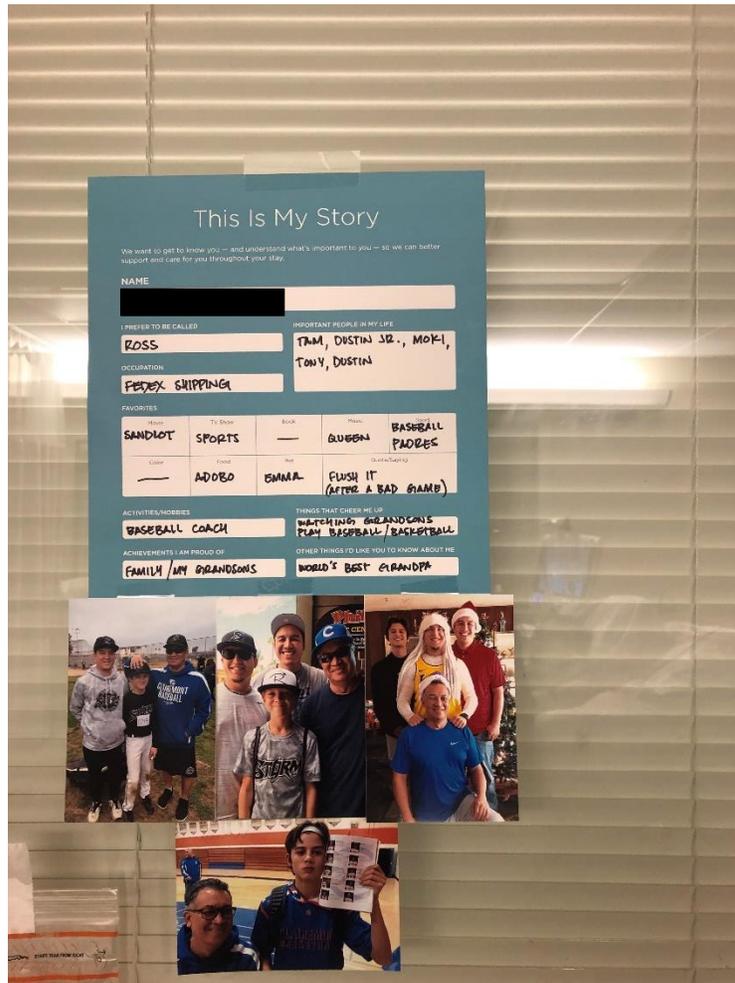
Jean Watson, PhD,RN,AHN-BC,FAAN, LL(AAN)  
Founder/Director Watson Caring Science Institute  
Distinguished Professor/Dean Emerita University of Colorado Denver  
[www.watsoncaringscience.org](http://www.watsoncaringscience.org)  
[jean@watsoncaringscience.org](mailto:jean@watsoncaringscience.org)  
[jeanwatson@comcast.net](mailto:jeanwatson@comcast.net)



Watson Caring  
Science Institute

---

Appendix N: Completed Poster Example



Permission obtained from patient to use poster for publication

## Appendix O: Descriptive Statistics of WCPS questionnaire

Variables	Surgical ICU (N=102)	Medical ICU (N=97)	P-value <sup>1</sup> (N=199)
<b>Create a caring environment that helps me to heal [n (%)]</b>			
1 Never	1 ( 1.0)	0	<.0001*
2	0	3 ( 3.2)	
3	1 ( 1.0)	15 (15.8)	
4	1 ( 1.0)	49 (51.6)	
5	7 ( 6.9)	22 (23.2)	
6	46 (45.1)	5 ( 5.3)	
7 Always	46 (45.1)	1 ( 1.1)	
<b>Deliver my care with loving-kindness [n (%)]</b>			
1 Never	1 ( 1.0)	0	<.0001*
2	0	4 ( 4.2)	
3	2 ( 2.0)	5 ( 5.3)	
4	1 ( 1.0)	56 (58.9)	
5	23 (22.5)	24 (25.3)	
6	55 (53.9)	6 ( 6.3)	
7 Always	20 (19.6)	0	
<b>Have helping and trusting relationship with me [n (%)]</b>			
1 Never	1 ( 1.0)	0	<.0001*
2	0	5 ( 5.3)	
3	1 ( 1.0)	12 (12.6)	
4	2 ( 2.0)	39 (41.1)	
5	10 ( 9.8)	33 (34.7)	
6	47 (46.1)	5 ( 5.3)	

Variables	Surgical ICU (N=102)	Medical ICU (N=97)	P-value <sup>1</sup> (N=199)
7 Always	41 (40.2)	1 ( 1.1)	

Note: ICU = Intensive Care Unit, SD = Standard Deviation, Min = Minimum, Max = Maximum, % =100 x (n/N)

"This is My Story" patient personalization poster was implemented in the Surgical ICU

<sup>1</sup> P-values are computed using either t-test for continuous variables or Wilcoxon two-sample test for categorical variables

\*Significant difference between medical and surgical units is demonstrated at 5% significance level (i.e. P-value < 0.05)

Variables	Surgical ICU (N=102)	Medical ICU (N=97)	P-value <sup>1</sup> (N=199)
<b>Meet my basic human needs with dignity [n (%)]</b>			
1 Never	1 ( 1.0)	0	<.0001*
2	0	4 ( 4.2)	
3	0	9 ( 9.5)	
4	4 ( 3.9)	41 (43.2)	
5	7 ( 6.9)	34 (35.8)	
6	61 (59.8)	7 ( 7.4)	
7 Always	29 (28.4)	0	
<b>Value my personal beliefs and faith, allowing for hope [n (%)]</b>			
1 Never	1 ( 1.0)	2 ( 2.1)	<.0001*
2	0	5 ( 5.3)	
3	1 ( 1.0)	24 (25.3)	
4	7 ( 6.9)	40 (42.1)	
5	12 (11.8)	18 (18.9)	
6	46 (45.1)	5 ( 5.3)	
7 Always	35 (34.3)	1 ( 1.1)	
<b>Mean Score</b>			
n	102	97	<.0001*
Mean (SD)	6.1 (0.85)	4.1 (1.01)	
Median	6.2	4.0	
Min - Max	1.0 - 7.0	0.0 - 6.6	

Note: ICU = Intensive Care Unit, SD = Standard Deviation, Min = Minimum, Max = Maximum, % =100 x (n/N)

<sup>1</sup> "This is My Story" patient personalization poster was implemented in the Surgical ICU  
<sup>1</sup> P-values are computed using either t-test for continuous variables or Wilcoxon two-sample test for categorical variables

\*Significant difference between medical and surgical units is demonstrated at 5% significance level (i.e. P-value < 0.05)

## Appendix P: Staff Education Evaluation

Variables	Surgical ICU (N=52)
<b>The “This My Story” educational presentation increased my understanding of the use of patient personalization posters [n (%)]</b>	
Strongly agree	42 (80.8)
Agree	10 (19.2)
Neither Agree nor Disagree	0
Strongly Disagree	0
<b>I will use the patient personalization posters: “This is My Story” when caring for patients/families [n (%)]</b>	
Very Likely	44 (84.6)
Likely	8 (15.4)
Neither Likely nor Unlikely	0
Unlikely	0
Very Unlikely	0

---

Note: ICU = Intensive Care Unit, % =100 x (n/N)  
 “This is My Story” patient personalization poster was implemented in the Surgical ICU

## Appendix Q: Post-implementation Staff Evaluation

Variables	Surgical ICU (N=52)
<b>I am familiar with the “This is My Story” posters? [n (%)]</b>	
Extremely Familiar	11 (44.0)
Very Familiar	12 (48.0)
Somewhat Familiar	2 ( 8.0)
Not So Familiar	0
Not At All Familiar	0
<b>The “This is My Story” posters were helpful in creating a connection with my patient? [n (%)]</b>	
Strongly agree	13 (52.0)
Agree	7 (28.0)
Neither Agree Nor Disagree	4 (16.0)
Disagree	1 ( 4.0)
Strongly Disagree	0
<b>What is your role? [n (%)]</b>	
RN	25 (100)
HCP	0
Other	0
<b>What shift do you work? [n (%)]</b>	
Dayshift	15 (60.0)
Nightshift	10 (40.0)
<b>How long have you been in your role? [n (%)]</b>	
< 1 year	2 ( 8.0)
1-3 years	9 (36.0)
4-6 years	7 (28.0)
7-9 years	2 ( 8.0)
10-15 years	3 (12.0)

Variables	Surgical ICU (N=52)
> 15 years	2 ( 8.0)

Note: ICU = Intensive Care Unit, % =100 x (n/N)

“This is My Story” patient personalization poster was implemented in the Surgical ICU

\*\*\*Note: This project was undertaken as a Quality Improvement project, and was not formally reviewed by JU's IRB.