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Design and Development of an Educational Intervention on Nurse Perceptions of Caring

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This is to certify that the doctoral study by

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Walden University
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Abstract

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Project Submitted in Partial Fulfillment

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Doctor of Nursing Practice

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Abstract

Caring is central to the nursing profession and important to patients and family members who expect nurses to display caring attributes. The acute care hospital in this study did not have an education program on caring practices for nursing staff although the organization acknowledged the importance of and need for a culture of caring practices in the organization. The purpose of this project was to design an educational program based on Watsons' theory of caring for registered nurses at the acute care hospital where the project took place. Rosswurm and Larrabee's model for change and Watson's theory of caring were the frameworks used to guide the project. The practice-focused question asked if a caring nursing education program could be developed after assessing the level of caring of the staff in addition to evidence-based practice literature. The Caring Factor Survey-Care Provider, a 20-item survey, was used to have staff rank Watson's 20 caring factors on a 7-point Likert scale. Data from the surveys were collected from 37 registered nurses on the medical surgical nursing unit; then, results were tabulated and used in the development of a caring education curriculum. Results indicated a mean range from 4.70 to 6.75 with perception of being respectful of patients' individual spiritual beliefs and practices (mean score of 6.75) ranking highest and creation of a helping and trusting relationship lowest (mean score of 4.70). Items where staff scored a mean score less than 5 were incorporated into the education curriculum. The caring educational program may bring positive social change to the acute care hospital by changing the culture of nursing and nursing practice toward an awareness of caring and caring science.

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Dedication

This project is dedicated to all aspiring nursing students joining the most prestigious profession of nursing, assisting those who need your caring, compassion, knowledge, skill, and expertise from your nursing practice and education.

Acknowledgments

I would like to thank my program chairs, Dr. Anne Vitale and Dr. Janice Long, for their knowledge, skill, and guidance in assisting me to complete this scholarly educational endeavor.

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I would also like to thank my parents, John and Corinne, for their support and encouragement. I undertook this important and meaningful step in my life to fulfill my educational goals to better serve the community through my nursing profession. You have both always been there for me and provided the guidance, encouragement, and love to keep going when I felt overwhelmed.

Table of Contents

List of Tables

List of Figures

Section 1: Overview of the Evidence-Based Project

Introduction

Caring is a central component of the nursing profession, yet nurses may lack knowledge about the science of caring within the discipline of nursing. The Institute of Medicine report, *Crossing the Quality Chasm* (2001), supported patient-centered care that is responsive to individual patient preferences, and such care should be the basis for all clinical decisions that are made for the patient despite the differences in the perceptions of care between the patient and the nurse. Below average Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores at both national and state levels have motivated acute care hospitals to explore other resources or opportunities to improve scores related to the patient perceptions of caring during their hospital stays (Centers for Medicare & Medicaid Services, 2014). Health care organizations will continue to explore and look for new ways to improve patient satisfaction, patient safety, and quality of care as demonstrated in the HCAHPS survey scores (Centers for Medicare & Medicaid Services, 2014). Administrators in health care organizations may influence nursing practice by creating practice environments that improve the patient care experience of being cared for by nurses (Dyess, Boykin, & Rigg, 2010). Designing and implementing a caring educational program for nurses based on a caring theoretical foundation may inform nurses of the knowledge of caring science and translation into caring nursing practices in acute care hospitals with the outcome of improved patient perceptions of caring by nurses as measured by HCAHPS survey.

Background

The concept of caring and its relationship to the nursing profession and practice has been discussed throughout the literature by several nurse scholars (Henderson et al., 2007; McCance, 2003; Watson, 2008). Nurse scholars have many variations of the concept of caring. Defining the attributes of caring remains elusive. Numerous studies have been published on caring and associated caring behaviors and on the measurement of caring and caring attributes (Henderson et al., 2007; McCance, 2003; Watson, 2008). Other studies have focused both on caring as perceived by patients and nurses (Brooks-Carthon, Kutney-Lee, Sloane, Cimiotti, & Aiken, 2011; Pearcy, 2010; Weiser, 2012; Wolf, 2012). In summary, research on the concept of caring and associated caring attributes will continue to be studied until a consensus is reached within the nursing profession as to the meaning of caring.

Caring and the concept of caring has become essential to the viability of hospitals. Hospitals participate in the HCAHPS survey to measure caring and other variables in the care environment during patient hospital stays (Centers for Medicare & Medicaid Services, 2014). HCAHPS survey scores are designed and intended for hospitals to self-evaluate opportunities to improve care in the care environment (Centers for Medicare & Medicaid Services, 2014). The goals of the Centers for Medicare and Medicaid Services to be achieved through HCAHPS surveys are to (a) to improve the quality of care, (b) enhance the accountability in the health care provided. and (c) provide data on topics that are important to patients and consumers (Centers for Medicare & Medicaid Services, 2014). The care environment includes the measures of (a) communication with patients,

(b) responsiveness to a patient's needs, (c) pain management, (d) communication about medications, (e) essential information provided at discharge, (f) patient's understanding of care after leaving the hospital, (g) cleanliness of rooms, and (h) quietness at night (Centers for Medicare & Medicaid Services, 2014). The aforementioned measures comprise the HCAHPS survey and are reported as an individual and as a total composite score for the care environment in acute care hospitals.

In 2005, the enactment of the Deficit Reduction Act prompted acute care hospitals to participate in HCAHPS through a financial incentive (Centers for Medicare & Medicaid Services, 2014). The financial incentive involved hospitals that were subject to an Inpatient Prospective Payment System (IPPS) annual payment. The IPPS required hospitals to collect and submit HCAHPS data to receive the full annual payment (Centers for Medicare & Medicaid Services, 2014). The Patient Protection and Affordable Care Act of 2010 also created a financial incentive for hospitals. The incentive is based on improving the patient care experience in HCAHPS scores through the inclusion of hospital performance in the calculation of the payment in the Hospital Value-Based Purchasing (HV-BP) program (Centers for Medicare & Medicaid Services, 2014).

Background of Local Context

The overall HCAHPS scores at the acute care hospital that demonstrates the care experience was 70.46% and 68.10% for the medical-surgical nursing unit for the first quarter of 2015. The overall HCAHPS score for the site was 67.09% and 68.20% for the medical-surgical nursing unit for the year of 2014. The average score in California hospitals in 2014 was 68.78%, whereas the national average was 72.89%. In 2014 and

the first quarter of 2015, the HCAHPS average score for the medical-surgical nursing unit at this site was below that of the state and national averages. HCAHPS survey scores are calculated by the number of patients after discharge that report the most positive response to the HCAHPS survey questions related to the care environment measures (Centers for Medicare & Medicaid Services, 2014). Scores below the state and national average will affect hospitals' annual financial payment from the IPPS and HV-BP programs (Centers for Medicare & Medicaid Services, 2014).

To address the below-average HCAHPS scores for the medical-surgical nursing unit, hospital administration at the acute care hospital approved and implemented a caring based education program, the Heart, Head, Hand program (Galvin, 2010) in 2014. The goal of implementing the Heart, Head, Hand education program was to improve caring skills of all staff at the acute care hospital. The educational program provided training for all staff to develop their caring skills through case studies, in order to be informed of better caregiving experiences for patients. The training was not based on a nursing theoretical framework and was implemented once in 2014. The instructor of the Heart, Head, Hand program discontinued the program and it would not be repeated. Therefore, the decision to not continue the Heart, Head, Hand program was based on (a) not achieving the goal of improving caring skills of staff, (b) the lack of a nursing theoretical framework, and (c) incorporation into practice by nurses was difficult.

Nurses at this acute care hospital may have varying perceptions of the attributes that constitute caring in nursing. Caring perception similarities may be related to attending the Heart, Head, Hand program, whereas the differences in nurses' perception

of caring may be related to the diversity of the workforce such as age, gender, and ethnicity. At the acute care hospital, a consistent education program focused on caring practices in nursing does not currently exist. It is important to provide an ongoing educational program on caring for all newly hired nurses to be consistent with the expectations of the institution and enable nurses to practice caring behaviors. To this end, the chief nursing officer at the acute care hospital requested that I develop an educational program for nursing staff based on caring science that can introduce nurses to practices posited in the science of caring. The main goals of a caring-based educational program are to inform nurses of the science of caring, enhance nurses' perception of caring, and improve HCAHPS scores.

Problem Statement

The problem that I addressed at the acute care hospital where the project took place was the need for developing a theoretically based educational program on caring. It was not clear what was generally known by the nursing staff at this acute care hospital with regard to caring theory and caring nursing practices. The need to improve in overall HCAHPS performance was generally understood by the administration. For that reason, the Head, Heart, Hand program was implemented by administration in 2014 with the goal of improving the staffs' caring skills. The program was not implemented thoroughly, and it was not reevaluated by administration or based on a caring theoretical framework. The hospitals' administrative team recognized that caring, as perceived by patients, is currently below the national and state HCAHPS averages despite implementing the Head, Heart, Hand program. The hospitals' administrative team continued to seek other means

and resources to improve HCAHPS scores. The chief nursing officer recommended an educational program based on caring science, such as Watson's theory of caring, because this nursing theory was aligned with the clinical site's mission and vision statement. Foundational and continuing nursing education in the acute care setting based on the science of caring exists in the literature, and further supports the incorporation of caring in nursing educational programs (Boev, 2012; Caruso et al., 2008; Cook & Cullen, 2003; Curtis & Jensen, 2010; Desmond et al., 2014; Glembocki & Dunn, 2010; Herbst, 2008; Wolf, 2012).

The PICO statement is as follows:

P: Medical-surgical nurses at the practicum site.

I: Nursing education posited in Watson's theory of caring.

C: XXXXXXXXXXXXXX.

O: Results of improved Caring Factor Survey–Care Provider Version (CFS-CPV) and improvement in HCAHPS scores.

Purpose Statement

The purpose of the project was to design an educational program based on Watson's theory of caring (Watson, 1979). Watson's theory of caring emphasizes the humanistic side of nursing, and also combines knowledge from the various sciences and nursing practice (Watson, 2008). The spiritual dimension has also been incorporated into nursing practice to promote love and caring as cosmic forces to promote healing (Watson, 2008). Watson's theory of caring defines the nurse/patient relationship and interaction,

establishing an essential caring relationship and deep understanding of the patients' perspective to form a mutual bond (Watson, 2008).

This project involved incorporating the science of caring into nursing practice through the design and development of an educational program for nurses, using Watson's theory of caring as a foundation. The caring educational program that I developed in this project will be implemented by the acute care hospital and will introduce and inform practicing nurses about the discipline of nursing as a caring science. The educational program may bridge the gap between the science of caring knowledge and translation into caring nursing practices at the acute care hospital.

Goals and Objectives

My aim of the project was to develop an educational program based on caring using an evidenced-based approach. The goals of the project were to inform nurses of the science of caring, and to enhance the perception of caring by nurses. I structured and designed the educational program using specific learning objectives from the results of the CFS-CPV (Nelson & Watson, 2012). Nelson and Watson (2012) structured the survey on the 10 dimensions of caring contained in Watson's theory of caring. The educational program introduced nurses to Watson's theory of caring.

Frameworks for the Project

I used Rosswurm and Larrabee's model for evidence-based practice change to provide an overall systematic approach to implementing and translating an evidence-based practice change through the development of the educational program (Rosswurm & Larrabee, 1999). I used Watson's theory of caring as the foundation of the educational

program. The approach provided a contextual understanding of the science of caring and the carative factors that are the essence of the theory of caring, along with the corresponding caritas process (Watson, 2008). Watson's theory of caring, as the theoretical framework, provided a foundation for the design and content development of the interventional education program of caring. I discuss these theoretical frameworks in Section 2.

Nature of the Project

The project design was a staff development project using an evidence-based approach and Watson's theory of caring (Watson, 1979). Full- and part-time registered nurses from the medical surgical nursing unit located on the third floor were invited to complete the CFS-CPV (Nelson & Watson, 2012). I used the CFS-CPV results to tailor the education program for this unit. The chief nursing officer and the medical surgical nursing director supported the administration of the CFS-CPV to the registered nurses on a voluntary basis. A total count of forty-four surveys were provided to ensure the surveys were available to registered nurses volunteering to participate.

Definition of Terms

I used the following definitions to guide this project:

Carative factors: Essential core activities and orientation of professional nursing when providing nursing care (Watson, 1979).

Caring Factor Survey–Care Provider Version (*CFS-SPV*)*:* A tool developed to examine the human attribute of caring and universal love (Watson, 2009).

Caring science: An evolving field of study that is philosophical-ethical-epistemic and is grounded in the nursing profession (Watson, 2008).

Caritas processes: Transposed from the carative factors to a more meaningful language of caring that is based on five cultivated areas (Watson, 2008).

Concept of caring: Refers to a science that embraces a humanitarian, human science orientation, as well as caring processes and other experiences (Watson, 2008).

Holism: A focus on the whole person (Klebanoff & Hess, 2013).

Holistic caring roots: Philosophy of living and being that is grounded in caring, relationships, and interconnectedness (Klebanoff & Hess, 2013).

Head, Hand, Heart program: Caring education program with a focus on knowledge for the head (knowledge), hand (skills), and heart (human dimensions) (Galvin, 2010).

Hospital Value-Based Purchasing program: A system of payment for inpatient care services based on the quality of care provided (Centers for Medicare & Medicaid Services, 2014).

Inpatient Prospective Payment System (*IPPS*): A system of payment for the operating costs of acute care hospital inpatient stays based on prospective set rates (Centers for Medicare & Medicaid Services, 2014).

Rosswurm and Larrabee's model: A systematic process for change to evidence-based practice (Rosswurm & Larrabee, 1999).

Watson's theory of caring: A nursing theory that defines the nurse caring relations that are based on the Ten carative factors (Watson, 1979).

Hospital Consumer Assessment of Healthcare Providers and Systems (*HCAHPS*): A standardized survey completed by discharged patients for their input into measuring caring and other variables in the care environment during hospitalization (Center for Medicare & Medicaid Services, 2014).

Assumptions and Limitations

Assumptions

Assumptions are accepted statements that have not been scientifically tested but are considered to be true without scientific proof (Grove, Burns, & Gray, 2013).

This project included the following assumptions:

1. Nurses interested in participating in the CFS-CPV are keen to learn more about the science of caring.
2. Nurses interested in completing the CFS-CPV will be truthful in their responses.
3. The clinical site will implement the educational program when developed.

Limitations

Limitations are considered weaknesses or restrictions in the design, sampling, and data collection of the project that would make the findings less generalizable (Grove et al., 2013).

This project includes the following limitations:

1. The survey results from the medical surgical nursing unit may not be generalizable to other nursing units**.**

2. Conflict with work schedules may interfere with nurses' participation in the CFS-CPV .
3. The administration of the CFS-CPV posttest at the clinical site may not be done promptly after the education program
4. The staff nurses, administrative nurses, nursing director, and the chief nursing officer may have different notions of the concept of caring.

Significance of the Project

Patients and family members expect nurses to display caring behaviors while performing their duties in providing nursing care at all times. Instances of uncaring behaviors are currently being reported by patients and family members at a global level in the literature; consequently, uncaring behavior negatively affects both patient care and the profession of nursing (Cowar, 2013; Douglas, 2010). The significance of developing an educational program based on Watson's theory of caring introduces and provides nurses with a contextual understanding of nursing as a caring science and may enable nurses to incorporate theory into nursing practice (Watson, 2008).

Summary

Section 1 was an overview of the literature on the concept of caring and caring attributes in the nursing profession. The definition of *caring* is a continual discussion that must occur until consensus is reached within the nursing profession. The concept of caring has become essential to the viability of hospitals in the United States. I discussed hospitals participating in HCAHPS survey in relation to self-evaluation with the aim of identifying and improving care in the care environment. The problem I have highlighted

addresses the need to develop an educational program on caring based on a caring theory. The foundation of the educational program consists of Rosswurm and Larrabee's model, Watson's theory of caring, results of the CFS-CPV, and input from the project team. The development of the educational program is significant to the nursing practice because it has introduced and provided nurses with a contextual understanding of nursing as a caring science and may enable nurses to incorporate theory into practice.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

The purpose of this project was to develop an educational program for nurses using Watsons' theory of caring as a foundation to facilitate nurse knowledge of the science of caring. I reviewed the scholarly literature to support the educational needs of caring in nursing, and to provide direction to base this on current perceptions of caring among nurses. In Section 2, I explore and examine the scholarly literature related to holistic caring, concept of caring, concept of knowing, and caring theories in nursing. I also reviewed perception of caring by nurses, caring science in nursing education, and health care organizations. I discussed the theoretical frameworks that guided the development of the educational program.

Literature Search Strategies

The initial literature search I conducted electronically using the following databases: CINAHL, Medline, PubMed, and the Cochrane Library. Articles reviewed were less than 15 years old, unless they were considered classic research publications or articles. Terms that I used in the initial search included *caring*, *caring science*, *science of caring*, *nurse perceptions*, *nurse caring*, *caring attributes*, *Watson's theory of caring*, *caring nursing theories*, *carative factors*, *nurse caritas process*, *caring relationship*, *human caring*, *caring theory*, *knowing*, and *knowing the patient*. The initial search produced more than 150 peer-reviewed journal articles published between 1990 and 2015. I discarded articles if they did not contain relevant information related to an educational program on caring.

I performed an additional literature search in CINAHL, Medline, PubMed, and the Cochrane Library with a narrowed publication range of 2005 to 2015. I used the following search terms narrow the search: *caring*, *caring science*, *education on caring*, *implementing caring theory*, and *nursing clinical practice and caring*. I also used Boolean phrases with the terms listed previously to elicit a larger volume of articles. I selected a final total of 44 articles. I sorted and grouped the articles into the following common themes: caring in nursing, concept of caring, knowing, caring theory in nursing, perception of caring by nurses, caring science in nursing education, caring in health care organizations, nurse patient relationship and caring, nursing education and caring, caring and holistic nursing, history of caring in nursing, caring behaviors, and measuring caring.

Concepts, Models, and Theories

Holistic Care in Nursing

Nightingale (1932) posited that all disease, at some point in its development, is a reparative process in which nature tries to remedy the disease process. According to Nightingale's hypothesis, the symptoms of the disease are not symptoms of the disease process, but rather the want of fresh air or light, of warmth, of quiet, of cleanliness, or of punctuality in the administration of care (Nightingale, 1932). In caring for individuals, nurses must assist the reparative process and place the patient in the best position for nature to act by using fresh air, light, warmth, cleanliness, quiet, and the proper selection of diet (Nightingale, 1932). The conception of proper positioning of the patient by nurses for nature to act upon is the origin of the caring-healing relationship between nurses and patients (Watson, 2008) and continues today to aid in the reparative process. Nightingale

(1932) and Watson (2008) reinforced the importance of nurses to embrace the caring-healing relationship between the nurse and the patient. The caring-healing relationship between the nurse and the patient supports the educational program and was incorporated into the curriculum.

Concept of Caring in Nursing

Research focusing on the concept of caring was analyzed to inform the development of the educational program. The concept of caring was described in the literature from the perspective of patients and family members, yet few have described the attributes associated with caring from a nurse's perspective. On the other hand, limited evidence and knowledge were present in the literature as to what constitutes caring and the behaviors associated with this concept as perceived by nurses, as compared to the patient and family members' perception**.** Patients have identified the caring behaviors of nurses in a number of ways, including the development of meaningful relationships, communication, and the provision of time for the patient (Henderson et al., 2007).

Caring as a concept, has gained popularity in the literature, and more research studies are focused on measuring caring as perceived by both patient and nurse alike (Brooks-Carthon et al., 2011; Pearcey, 2010; Wolf, 2012). Swanson (1993) posited that the structure of caring consists of five caring processes, which are (a) *maintaining belief*, (b) *knowing*, (c) *being with*, (d) *doing for,* and (e) *enabling*. Each of these attributes displayed by a nurse and caring processes synergistically worked in tandem for the good of the client to achieve the intended outcome of wellbeing (Swanson, 1991). Swanson

(1991) recommend incorporating caring attributes and caring processes into nursing practice and education.

Henderson et al. (2007) conducted a qualitative study utilizing observation methodology and questionnaires from patients who were discharged during the data collection period. The study indicated that patients attribute and associate caring in nurses when nurses responded to their requests (Henderson et al., 2007). The researchers demonstrated that a nurse patient relationship should be established to inform nurses of patients' expectations and needs. Establishing a nurse patient relationship supports the caring educational program and was incorporated into the curriculum.

McCance, Slauter, and McCormack (2008) conducted a quasi-experimental study to measure caring to evaluate person-centered nursing. A pretest posttest design was used to measure the nurse's and patient's perceptions of caring. The Caring Dimensions Inventory, the Nursing Dimensions Inventory, and the Person-Centered Nursing Index were all used to measure the concept of caring as perceived by nurses as well as by patients. The results showed that nurses had a clear understanding of caring and the elements of caring, as opposed to the patient's perceptions of caring, which were found to be variable and incongruent. McCance et al. (2008) determined that these tools could be used in the clinical setting to measure nurses and patient's perceptions of caring as it relates to person centered practice**.**

Birk (2007) described the implementation of Watson's theory of caring into the culture of an acute care hospital. Subsequently, a pilot study was conducted to examine the caring behaviors of the nurses as perceived by the patients. The pilot study revealed a

renewal of caring behaviors from the nurses, with these behaviors affecting the patients' perception of care (Birk, 2007). The researcher recommends that Watson's theory of caring be systematically incorporated into nursing services throughout the acute care hospital through an educational program for staff (Birk, 2007).

Concept of Knowing

The concept of knowing forms part of the structure of caring in nursing (Swanson, 1993). Nurses strive to understand the realities of current events in the lives of patients, and how current life events affect the patients' wellbeing (Swanson, 1993). Nurses attain an understanding of the patient through getting to know patients' realities (Swanson, 1993). Furthermore, nurses' knowledge of knowing a patient, along with expert nursing judgment has been associated with positive patient outcomes (Zolnierek, 2014).

Zolnierek (2014) conducted an integrative review regarding nurses getting to know patients. The act of a nurse *knowing* a patient has demonstrated a strong association with providing safe care, having a meaningful relationship with the patient, and providing expert care (Zolnierek, 2014). The researchers also demonstrated that the work environment where care takes place affects the process of knowing the patient, as it does not always provide the conditions necessary to fully support the process (Zolnierek, 2014).

In nursing literature, the *use of self* has been associated with the concept of personal knowing and refers to the discovery of the self and others through the process of reflection (Watson, 1985). The *use of self or personal knowledge* can be associated through feelings, experience, and transcendental processes (Watson, 1985). Nurses have

a significant opportunity to develop personal knowing when engaging with both patients and family members. The engagement of personal knowing promotes wholeness during the encounter, while also promoting personal orientation (Watson, 1985).

Besides personal knowing, there are other modes of knowing that nurses use in their practice, some of which are defined as empirical, ethical, and aesthetic. Empirical knowing focuses on facts in order to predict and/or explain (Zander, 2007). Ethical knowing focuses on moral values and provides guidance in knowing exactly what needs to be done or completed for the patient (Zander, 2007). Aesthetic knowing focuses on the nurses' perception of the patient as a whole, while also considering the patients' needs (Zander, 2007). Therefore, nurses utilize all four types of knowing to better understand the patient and provide a high quality of care (Zander, 2007). I incorporated the four modes of knowing into the education program content.

Caring Theories in Nursing

Theories have been described as the systematic explanation of an event that is used in a profession where certain variables align, thus distinguishing it from other professions (McEwen & Wills, 2011). Nursing theories help to define nursing practices, and also to establish boundaries within the profession; in turn, nursing theories help to distinguish it from other professions in caring (McEwen & Wills, 2011). Several nurse theorists have explained the phenomenon of caring in the nursing profession, Watson's (1979, 2002, 2005, 2010) theory of caring, Swanson's (1991) care theory, and Leininger's (1991) cultural care diversity and universality theory, Duffy's (2003) quality caring model, Noddings's (1992) caring ethics theory, and Halldorsdottir's (1996) theory

of caring and uncaring behaviors. The caring theories were reviewed and considered by nursing administration at the acute care hospital. The decision was made by nursing administration to use Watson's theory of caring as the foundation for the caring educational program for nurses at the acute care hospital. Leininger's (1991) cultural care diversity and universality theory and Nodding's (1992) caring ethics theory provides support for the educational program for nurses and a brief overview of the theories was provided.

Watson's theory of caring (1979) provides ten carative factors that are the core and essential aspects of caring in nursing. The ten carative factors provide a framework for the profession of nursing with a deeper understanding of the human dimension of caring (Watson, 1979). The carative factors are the essential activities used by nurses in providing nursing care (Watson, 1979, 2008). Watson's theory of caring continues to evolve and expand further upon the earlier works on caring (Watson, 2008).

Leininger (1991) recognized the interaction between social and cultural aspects of caring within nursing practice. Social and cultural awareness has led to the development of the culture care diversity and universality theory. The theory is broad and holistic in that the focus is culture specific to provide nursing care that is meaningful to various cultures (Leininger, 1991). The purpose of the theory is to assist nurses to better understand cultural factors that may influence health and wellbeing of various cultures (Leininger, 1991). Culturally based nursing care and knowledge has advanced to culturally congruent nursing care to persons of different cultures. The goal of the culture care diversity and universality theory is to provide culturally congruent nursing care

(Leininger, 1991). Culturally congruent care is foundational to the nursing education program.

Noddings's caring ethics theory was built on the premise that caring for others is a learned process, as well as a social process that is based on good moral education (Noddings, 1992). Nodding's feminist perspective in dealing with personal problems is that she believes in a woman's approach to caring for a person, with the aim of gaining a deeper understanding of the circumstances. Two constructs of her theory are natural caring and ethical caring, which are distinct from each other. When nurses encounter a patient in need, they have the impulse to naturally care for the patient, and may also encounter ethical conflict within the nurses' own desire to not provide the care. It is at this point that nurses enter the ethical caring mode in which nurses provide the natural care needed based on good moral education (Noddings, 1992). In summary, Nodding's theory enhances and raises nurses' awareness of natural caring and ethical consciousness in providing nursing care to patients. Raising nurses' awareness to caring concepts is foundational to the educational program and supports Watson's views of transpersonal caring in nursing.

Perception of Caring by Nurses

The concept of caring is the cornerstone of the nursing profession and is highly regarded by nurses (Swanson, 1991; Watson, 2008). The caring perceptions of patients and family members are well documented in the literature, and are also important in informing the nursing profession of patients and family members expectations of caring practices and attributes displayed by nurses (Brooks-Carthon et al., 2011; Pearcey, 2010;

Weiser, 2012; Wolf, 2012). The patient and the nurse perceptions of caring and caring behaviors have been incongruent as demonstrated in several research studies (Henderson et al., 2007; Papastavrou et al., 2011).

A systematic review conducted by Papastavrou et al. (2011) revealed that there are indeed discrepancies between patients' and nurses' perceptions of caring and caring behaviors. The systematic review demonstrated that nurses may plan caring based on their own assumptions, and not on patients' perceptions of caring (Papastavrou et al., 2011). Nurse perceptions of caring behaviors have been associated with the emotional and psychological aspects of the patient, and have been perceived by nurses as more important when compared to technical caring skills and behaviors associated with performing nursing tasks (Papastavrou et al., 2011). The discrepancies between the nurse and the patient may lead to the perception of uncaring. I addressed the patient perceptions of uncaring nursing behaviors in the educational program.

Bridges et al. (2013) conducted a study using meta-ethnographic method with the aim of synthesizing the evidence of the nurses' experiences in developing the nurse-patient relationship. The researchers demonstrated nurses utilize strategies to form a therapeutic relationship with patients that are both emotional and intimate (Bridges et al., 2013). The concept of caring moments, fundamental to the establishment of nurse-patient relationships I included in the educational program (Watson, 1985).

Caring Science in Nursing Education

Caring is central to the nursing profession, yet understanding the depth of this concept often eludes nurses and nursing students (Sitzman, 2007). Cook and Cullen

(2003) discussed the importance that nursing curricula are threaded with the concept of caring, as this is a vital component of the nursing profession. According to Watson (2008) "a caring science orientation to nursing education intersects with arts and humanities and related fields of study, beyond the conventional clinicalized and medicalized views of human and health-healing" (p. 255).

Adamski, Parsons, and Hooper, (2009) conducted a research study with the aim of determining whether clinical staff nurses would influence student perceptions of caring through storytelling. A pre- and posttest design was used employing Coates Caring Efficacy Scale (Adamski et al., 2009). The researchers demonstrated that there was no significant difference between the pretest and posttest scores (Adamski et al., 2009). Adamski et al. (2009) also demonstrated that the posttest scores were higher than the pretest scores, thus indicating a positive trend towards the increased perception of caring by nursing students. I used case studies and storytelling as teaching strategies in the educational program.

Curtis and Jensen (2010) conducted a descriptive qualitative study with the purpose of examining the use of confluent educational strategies for nursing students and its effects on learning, empathy, and caring for individuals of various cultures and socio-economic backgrounds. Confluent education places emphasis on combining cognitive and affective domain of learning (Stover, 2010). The researchers demonstrated the use of confluent educational strategies resulted in students having an increased awareness and developed meaning toward individual caring with low socio-economic levels and different cultures (Curtis & Jensen, 2010). I used confluent educational strategies in the

caring education program for nurses as a methodology for mentoring empathy and caring in the clinical setting

Valentine, Ordonez, and Millender (2014) described two nurse-managed-care centers operating out of Florida Atlantic University's Christine E. Lynn College of Nursing. The nurse-managed care centers utilize evidence-based practice for specialized care of patients with diabetes and Alzheimer's disease and holistic nursing practice. The two nurse-managed care centers are philosophically grounded and guided by caring science. Evidence-based practice and holistic nurse care promotes a healing relationship and may improve health and wellbeing of patients (Valentine et al., 2014). Holistic caring establishing a healing relationship between the nurse and the patient was applicable and supports the educational program for nurses in the project.

Watson's theory of caring has been used as a guide for advancing nursing practice and education in 82 universities worldwide (Watson, 2008). Nurse educators should incorporate the concept of caritas teaching and learning into nurse education to create caritas practitioners that are morally guided in practice (Watson, 2008). Caring science along with caritas consciousness strengthens our nursing values that can be integrated into education learning practices (Watson, 2008). Caring science as a context for nursing education creates an opening into human consciousness and embraces caritas thus allowing a deeper understanding of nursing (Watson, 2008). The profession of nursing has at its foundation human relationships and caring that should be a key foundational focus of nursing curricula (Watson, 2008).

A review of the nursing literature reveals various educational strategies focused on the concept of caring. These educational strategies include, affective learning and transformational learning theory in nursing curricula design (Brown, 2011). Affective learning and transformational learning theory incorporates caring behaviors into simulated nursing situations critical moments case study workshops on caring learning-centered curricula and caring through service learning (Brown, 2011; Candela, Dalley & Benzel-Lindley, 2006; Eggenberger, Keller, & Locsin, 2010; Schofield, Allan, Jewiss, Hunter, Sinclair, Diamond, & Sidwell, 2013). Subsequently, there does exist many educational strategies that are utilized in nursing student education regarding the concept of caring. Educational teaching strategies of affective learning and transformational learning theory will be utilized in presenting the components of the caring program in this project.

Caring Science in Health Care Organizations

The dynamic care environment along with the demands placed on nurses in the workplace has promulgated a shift in the importance of patient care to technological demands in order to meet regulatory requirements. Various educational strategies are used in transforming and adopting caring science in acute care settings. Caruso, Cisar, & Pipe, (2008) described the adoption of Watson's theory of caring in an acute care hospital and outpatient clinic. The rationale for this project was to inform nurses of Watson's theory of caring and to incorporate a caring theory into nursing practice (Caruso et al., 2008). Watson's theory of caring was first evaluated by nurse leadership and was found to be applicable to nurses across the health care continuum, to nurses and patients, as a

guide for nursing practice in all settings, and as a guide for nursing staff to articulate the essence of nurses and nursing practice (Caruso et al., 2008). Caruso et al. (2008) described utilizing educational approaches such as reflective activities and proved to be valuable in disseminating and adopting the theoretical perspectives of Watson's theory of caring and was incorporated into this educational project.

Persky, Nelson, Watson, and Bent (2008) conducted a nonrandomized study used a quasi-experimental design and a pre-and post-intervention survey of nurses in an acute care hospital. The CFS-CPV was administered to nurses to establish a baseline of caring in this study. Caring education for registered nurse was provided utilizing Watson's theory of caring (Persky et al., 2008). The CFS-CPV was again administered after six weeks to registered nurses. Pre-and post-scores on the CFS-CPV were compared using descriptive statistics (Persky et al., 2008). Persky et al., (2008) demonstrated CFS-CPV scores post intervention was significantly improved in that all scores were above four on a seven point Likert scale. The research revealed more nurse confidence in demonstrating caring behaviors with their patients (Persky et al., 2008).

Dyess et al. (2010) described a dedicated education unit that was grounded in caring in both its theoretical framework and also in educating nurses. The selection of nursing as a caring theory provided the foundations for knowing and other endeavors that influence nursing practice (Dyess et al., 2010). The researchers demonstrated that adopting a caring theory into a health care organization might result in transformative changes in the nursing practice environment (Dyess et al., 2010). The researchers

recommend caring educational program for nurses to use various educational strategies and to incorporate the educational strategies into the presentation.

Theoretical Frameworks Literature

Rosswurm and Larrabee's Model

Health care practitioners need skills to appraise, synthesize and incorporate the best evidence into practice (Rosswurm & Larrabee, 1999). Rosswurm and Larrabee's model for change to evidence-based practice (1999) processes provides practitioners the guidance necessary to develop and integrate an evidence-based practice change (Burns, Dudjak, & Greenhouse, 2009; Schaffer, Sandau, & Diedrick, 2012; Scott & McSherry, 2009). Rosswurm and Larrabee's model for change to evidence-based practice (1999) consist of a six-step process: assess, link, synthesize, design, implement and evaluate, and integrate and maintain. There are 20 sub-steps within the six-step process. The first step as to assess the need for change in practice and includes: involving stakeholders, collect internal data, compare internal data to external data, and identifying the problem (Rosswurm & Larrabee, 1999). The second step was to link problem to interventions and outcomes (Rosswurm & Larrabee, 1999). The third step was synthesizing best evidence in the literature and involves critiquing the evidence, assess benefits, risk, and feasibility (Rosswurm & Larrabee, 1999). The fourth step was to design a practice change involving defining the change in practice, identifying resources, plan implementation process, and define outcomes (Rosswurm & Larrabee, 1999). The fifth step is to implement and evaluate the change in practice by evaluating the process and outcomes, deciding to adapt, adopt, or reject the practice change (Rosswurm & Larrabee, 1999). The

sixth step is integrating and maintaining the change in practice by communicating change to stakeholders, present staff in-service education on change in practice, integrate into standards of practice, and monitor outcomes (Rosswurm & Larrabee, 1999). Steps five and six will be the responsibility of the acute care hospital. The acute care hospital has agreed to this responsibility. Rosswurm and Larrabee's model for change to evidence-based practice (1999) supported the project by providing a foundation and guide to translate the evidence to develop and implement the caring educational program for registered nurses.

Rosswurm and Larabees's Six-Step Process Utilized at the Acute Care Hospital

Rosswurm and Larrabee's model (1999) provided a systematic change beginning with assessing the need for change by examining internal data such as the HCAHPS scores on caring by nurses as perceived by patients. The data from the HCAHPS scores was one measure that stimulated the awareness for a need for change in nursing practice at the clinical site. Linking the identified problem of improving caring skills by registered nurses and the intervention of the development of an educational program on caring that is based on a caring theory framework, may demonstrate improved caring skills as reported by nurses and by patients at the acute care hospital. The third step, synthesizing best evidence on nurse caring through searching the literature and disseminating the results to key stakeholders at the clinical site. The fourth step was to design a practice change through the development of a theoretical based educational program on caring for registered nurses, develop a plan for implementation, and identify needed resources. The fifth step was to implement and evaluate the educational program

on caring for registered nurses. The educational program on caring will be implemented by the educator at the acute care hospital and a decision will be made whether to adapt, adopt, or reject the practice change. The final step is to integrate and maintain the change in practice at the clinical site by providing the educational program on caring for registered nurses and integrating the constructs of caring into standards of practice.

Watson's Theory of Caring

The chief nursing officer and other nursing administrators at the acute care hospital reviewed and considered Swanson's (1991) care theory, Leininger's (1991) cultural care diversity and universality theory, Duffy's (2003) quality caring model, Nodding's (1992) caring ethics theory, and Halldorsdottir's (1996) theory of caring and uncaring behaviors. Watson's theory of caring was selected as the theoretical framework for the project. The decision to utilize Watson's theory of caring was based on more of an alignment with the mission and vision of the clinical site. Watson's theory of caring informs the nurses of caring science.

Watson's theory of caring developed from Dr. Jean Watsons' initial 1979 attempt to embrace and bring meaning to nursing. The ongoing development of the theory combines Dr. Watsons' past clinical experiences, values, beliefs, perceptions, and doctoral studies in education and social psychology (Watson, 1979). The early work informs the core and structure of Watson's theory of caring that was the ten carative factors (Watson, 1979). The ten carative factors were the essential components of caring in nursing (Watson, 1979). The spiritual dimensions of caring were then incorporated and acknowledged as a part of healing in Watson's theory of caring (Watson, 1985). The

constructs developed included the caring occasion, caring moment, and transpersonal caring (Watson, 1985). Since then, this early work has evolved and informs connectedness between human caring for self, for others, and healing (Watson, 2008). The core elements of this theory are the ten carative factors, transpersonal caring relationship, caring consciousness, and caring occasion or caring moment (Watson, 2008)**.** Watson's theory of caring provided the foundation and framework to guide the development of the educational program for this project. I incorporated the core elements into the caring education program curriculum. Caring science helps to reclaim and reframe our values and deep understanding of that which is the foundation of nursing (Watson, 2008) and was instrumental in developing and designing the educational program.

Literature Review Related to Method

The concept of caring and associated caring attributes continues to be measured by nurse researchers and scholars using various methodologies of measurement (Herbst, 2008; Papastavrou et al., 2011; Pearcey, 2010; Nelson & Watson, 2012). The CFS-CPV developed to measure care providers' self-perceptions of displaying caring behaviors to patients in their care (Nelson & Watson, 2012). I chose the instrument for this project because the instrument measures caring based on Watson's theory of caring and the ten caritas processes. Medical surgical registered nurses on the third floor of the acute care hospital **were** invited to complete the survey. I analyzed the data results and used the results to develop the educational program. This methodology has been used previously

to develop educational programs on caring (Caruso & Pipe, 2006; Desmond et al., 2014; Persky, 2008).

Background and Context

The acute care hospital employs 44 registered nursing staff members on the medical surgical nursing unit. The ethnic background of the nursing staff is comprised of: 65% Filipino, 25% Latino, and 10% Caucasian. The highest level of nursing education held by two registered nurses is a master of science in nursing**.**

. My role in the project was to design and develop caring educational program for registered nurses based on the data gathered and analyzed from the CFS-CPV. Analysis of the CFS-CPV data were reported to the project team and key stakeholders for discussion, input and suggestions for the curriculum design. The acute care hospital was my practicum site and it serves as a clinical site for several nursing programs in the local area.

My previous experience as a staff nurse, clinical educator, clinical nurse specialist, and nursing director influenced the decision to focus on caring and associated attributes. Developing an educational program on caring for registered nurses as requested by the chief nursing officer at the acute care hospital has increased my knowledge base of caring science. I have had previous experience in developing educational programs for registered nurses as an educator and clinical nurse specialist.

Summary

The literature search focused on caring, specifically in the nursing profession, to guide the development of an educational program for registered nurses on caring. Caring has gained popularity in the literature and a vast amount of studies exist that are focused on both patients and family member's perceptions of caring. The concept of caring was discussed and is often associated with attributes such as attention, concern, providing for, knowing, explaining, responding, and watching over. The concept of knowing was discussed as a substructure of the concept of caring. Caring theories in nursing were reviewed to inform nursing practice. Nurses' and patients' perceptions of caring were reviewed in the literature, demonstrating incongruences between the two.

The CFS-CPV and its components I discussed as a measurement tool to provide guidance in the development of the education program curriculum. Caring science in nursing education was examined, determining that the concept of caring and associated attributes needs to be threaded in the nursing curriculum. Caring science in health care organizations was reviewed determining that adopting a caring theory could result in transformative changes in the nursing practice environment. Rosswurm and Larrabee's model for change to evidence-based practice was discussed and was used to provide an overall systematic approach to guide the project. Watson's theory of caring was expanded on, and constructs of the theory were explained that were used as the theoretical framework for the educational project. The educational program may bridge the gap between caring science knowledge and the translation into caring nursing practices.

Section 3: Methodology

Introduction

The purpose of the project was to develop an educational program for nurses with the foundation of Watson's theory of caring to facilitate caring in nursing practice at the acute care hospital. The chief nursing officer established the goal of improving patients' perception of care by nurses at the institution on the medical surgical nursing unit. In Section 3, I described the approach to the proposed project to develop an educational intervention using the theoretical frameworks of Rosswurm and Larrabee's model to systematically guide the project and Watson's theory of caring as a foundation for the educational program. I discussed the approach and rationale, context, population and sampling, strategies for recruiting participants and stakeholders. I also discussed the ethical considerations, data collection, and analysis. The curriculum development and delivery modality, implementation and evaluation plan I also presented and discussed.

Nurse perceptions of caring were evaluated through the administration of a survey using the CFS-CPV (Appendix B). I obtained permission from the authors to use the CFS-CPV in this work (Appendix A). I analyzed and incorporated the results into the design and development of an educational program. The foundation of the program was based on Watsons' theory of caring as the curriculum framework.

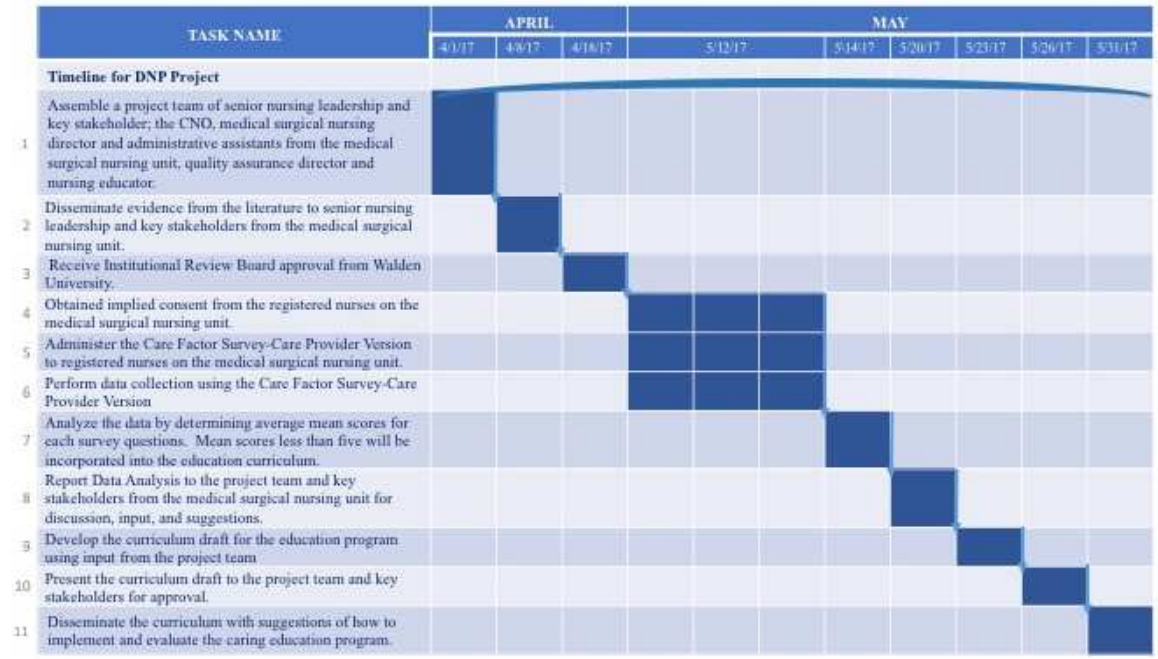

Figure 1. Gantt chart with project timeline.

A list of task steps assisted and guided the development of the educational project. Refer to the Gantt timetable (Figure 1).

1. Assembled a project team of senior nursing leadership and key stakeholders.
2. Disseminated evidence from the literature to senior nursing leadership and key stakeholders that supported the development of an educational program on caring for registered nurses.
3. Received Institutional Review Board approval from Walden University.
4. Obtained implied consent from the registered nurses on the medical surgical nursing unit.
5. Obtained support and secured a location to administer the CFS-CPV to registered nurses on the medical surgical nursing unit.

6. Performed data collection and analysis by determining mean scores for each survey statement. Mean scores of less than 5 were incorporated into the education curriculum.
7. Chief nursing officer reported data analysis to the project team and key stakeholders.
8. Developed the curriculum draft for the education program.
9. Presented the curriculum draft to the chief nursing officer for approval.
10. Disseminated the curriculum to the institution with suggestions of how to implement and evaluate the caring education program.

Approach/Rationale

The aim of the project was to provide an evidenced-based approach to a staff development initiative based on caring and includes methods from the literature, suggestions from key site stakeholders and the results of the CFS-CPV survey. I conducted the literature review with emphasis on synthesizing the best evidence from educational programs and strategies founded on Watson's theory of caring. I used the following search terms: *caring, caring science, caring science in nursing education, education on caring, implementing caring theory, and nursing clinical practice and caring.* I then grouped the articles into common themes that supported the education curriculum development. I conducted the initial literature search electronically using the following databases: CINAHL, Medline, PubMed, and the Cochrane Library.

Registered nurses on the medical surgical nursing unit were invited to participate in this project by completing the CFS-CPV survey (Nelson & Watson, 2012). I compiled

the data from the survey results and key points from the literature search to develop the curriculum draft for the caring education program. The caring education curriculum draft was provided to the chief nursing officer who shared the curriculum draft with the medical surgical nursing director, director of quality assurance, and the administrative nurses for input and suggestions.

The project approach was supported by a recent study conducted by Desmond et al. (2014), using a quasi-experimental design. The aim of the Desmond et al. study was to incorporate Watson's theory of caring into an acute care facility through the development of a caring educational program for nurses (Desmond et al., 2014). The researchers demonstrate that nurse confidence in caring attitudes and behaviors are statistically significant (Desmond et al., 2014). Hospital scores on the HCAHPS survey also demonstrated increases in the areas of courtesy, respect, and listening (Desmond et al., 2014).

Context and Population

The medical surgical nursing unit is located on the third floor of the clinical site and has 38 patient beds. Registered nurses on the medical surgical nursing unit are multigenerational and educational backgrounds vary from associate degree, bachelor in nursing, and master's degree in nursing. The population of nurses on the medical surgical nursing unit included new graduate and experienced night and day shift registered nurses who were invited to participate to complete the CFS-CPV survey.

Sampling and Recruitment

I invited all registered nurses working on the medical-surgical unit to participate in the CFS-CPV survey using convenience sampling methodology. I did not obtain identification of nurses. The sampling method is appropriate for the project as the nursing workforce at the acute care hospital included full-time, part-time, and per diem job classifications. Convenience sampling is a technique whereby subjects are included in a study as they are available to participate (Grove et al., 2012). The nurses that participated, completed, and returned the survey thereby giving implied consent were included in the project.

I attended shift huddles for the night and day shift to inform the nurses of the CFS-CPV and additionally posted flyers (Appendix C) in the break room and the nurses' station of the upcoming voluntary opportunity to participate in the survey. Attending shift huddles for the night and day shift assisted in developing a working relationship with the staff on the medical surgical nursing unit on both shifts. The conference room and the nurses lounge was used to administer the survey in order to provide staff an opportunity to participate. Ethical considerations are addressed below.

Project Team

The team consisted of four administrative nurses from the medical surgical nursing unit, the nursing director, the nurse educator, my preceptor, director of quality assurance, the chief nursing officer**,** and myself. The team members ensured that the nursing staff on the medical surgical nursing unit were informed of the project. The nurse educator participated and provided input into the teaching methodology of

Watson's theory of caring. The project team members for the educational project included the following duties:

1. I served as the project team leader and administered the CFS-CPV to the nursing staff and developed the curriculum**.**
2. The chief nursing officer of the acute care hospital promoted and lead efforts to implement the caring education program.
3. The nurse educator provided input into the teaching methodology to be used for the educational program.
4. My preceptor and I provided data analysis of the CFS-CPV.
5. The chief nursing officer was provided with the data analysis for review and shared the results with the medical surgical nursing director and the administrative nurses.
6. I developed a draft of the caring education curriculum based on the data from the analysis and current scholarly literature.
7. A caring education curriculum draft was provided to the chief nursing officer. The chief nursing officer presented and discussed the curriculum draft with the medical surgical nursing director, director of quality assurance, and the administrative nurses for input and suggestions.
8. The chief nursing officer and nursing administrative team had no suggestions and approved the curriculum.

Ethical Considerations

The approval of Walden University Internal Review Board, approval number 04-18-17-043422, was obtained prior to the start of this project and administration of the CFS-CPV. The acute care hospital accepted Walden's IRB approval. I invited the nurses on the medical surgical unit to participate on a voluntary basis. I provided nurses that participated with a written implied consent form.

The implied consent included privacy in a designated room, time for the nurses to read the consent and ask questions (Grove et al., 2013). The implied consent included an option to withdraw from the survey at any time without any penalties (Grove et al., 2013). The implied consent included the purpose of the project, background information of the project, procedures, voluntary nature of the project, risks and benefits of participating in the project, privacy, and contact information (Grove et al., 2013). Each nurse that agreed to participate received a copy of the implied consent form.

Data Management, Analysis, and Verification

I compiled the completed CFS-CPV surveys and I placed data on an Excel spreadsheet to calculate average mean scores for each question. Higher mean scores of 5 and above indicate a greater perception of caring by nurses (Desmond et al., 2014; Herbst, 2008; Nelson & Watson, 2012), while average mean scores of less than or equal to 5 indicate lesser perception of caring by nurses and was incorporated into the curriculum. The measure is appropriate for ordinal level data such as a Likert scale when higher values represent more of the variable being measured and lower numbers represent less (Grove et al., 2013).

I analyzed the results from the CFS-CPV (Nelson & Watson, 2012) survey. The DNP student's preceptor at the acute care hospital was given the results of the CFS-CPV (Nelson & Watson, 2012) and validated the analysis of the raw data. The alignment of the results served to verify the educational content incorporated into the design and development of the educational program. The CFS-CPV measures the perception of caring by nurses and scores of less than five were incorporated into the content of the education program. My committee chair, if needed, was available to verify alignment of results if there is any uncertainty.

Instrument

The project utilized the CFS-CPV as a survey for the registered nurses on the medical surgical unit of the hospital. The CFS-CPV has been used in previous studies to determine nurses' perceptions of caring in the clinical setting (Herbst, 2008; Nelson & Watson, 2012). The instrument consists of 20 statements based on Watsons' caritas processes, and focuses on agreement or disagreement on providing care to patients (Nelson & Watson, 2012). The instrument uses a 7 point Likert scale ranging from strongly disagree (1), neutral (4), to strongly agree (7). I obtained permission to use the CFS-CPV from the authors. I used the CFS-CPV as developed by the authors with no modifications of the instrument**.** The reliability of CFS-CPV has been validated and its psychometrics demonstrated as having Cronbach's Alpha score of 0.92 (Herbst, 2008; Nelson & Watson, 2012). The score indicates the CFS-CPV has strong internal reliability (Grove et al., 2013). The instrument comprises 20 items that are rated on a 7-

point Likert scale (Nelson & Watson, 2012). Higher scores are interpreted as a greater perception of caring by the health care provider (Nelson & Watson, 2012).

Products of the DNP Project

Curriculum Development

The purpose of the evidence-based staff development project was to develop an educational program using Watson's theory of caring as the theoretical framework. The CFS-CPV survey was administered at designated times to the nursing staff on the medical-surgical nursing unit. I collected and analyzed the results along with recommendations from the scholarly literature to design and construct a draft of the caring education curriculum. The education program content included an overview of Watson's theory of caring, carative factors, the transpersonal caring relationship, caring consciousness, and the caring occasion (Watson, 2008). The curriculum draft was presented to the chief nursing officer for review. The chief nursing officer presented the curriculum draft to the medical surgical nursing director, administrative nurses, and nurse educator for review, validation, and approval of content (Appendix D).

Educational Delivery Modality

The caring education program was designed to introduce nurses to the science of caring and facilitate nurses incorporating caring behaviors into nursing practice. A literature review of best practices of integrating Watson's theory of caring into nursing education programs suggests the initial presentation be four to eight hours in length and scheduled over a period of time so that all nurses may attend (Brown, 2011; Caruso et al., 2008; Desmond et al., 2014; Glembocki, et al., 2010; Sitzman, 2007; Valentine et al., 2014). The literature review suggested that the program format may be a workshop that includes using visual aids, didactics, and discussions as a means of teaching the

educational program to the nursing staff in hospitals (Brown, 2011; Caruso et al., 2008; Desmond et al., 2014; Glembocki, et al., 2010; Sitzman, 2007; Valentine et al., 2014). The nurse educator at the acute care hospital will provide continuing education units for nurses attending the caring education program as professional development

Develop Implementation Plan

I developed the implementation plan. The acute care hospital will administer the educational intervention. The implementation plan focused on how to implement the caring education program and included: (a) determining if the acute care hospital's budget will allow the caring education program to be presented to the medical surgical nurses, (b) determining dates, times, and length for the caring education program, (c) reserving a room for the presentation of the education program, (d) informing the staff nurses of the caring education program by the nursing director and administrative nurses, and (e) implementing the caring education program by the educator at the acute care hospital.

Develop Project Evaluation Plan

The suggested approach to the evaluation of the caring education program would be the comparison of the initial survey scores to that of the survey scores of the CFS-CPV post education implementation (Nelson & Watson, 2012). The educator at the acute care hospital would perform this measure after implementing the educational program. Additionally, it is recommended that HCAHPS scores attained in the care environment that include caring components can be examined to compare of scores in a pre-and post-fashion after all nurses on the medical surgical nursing unit have completed the caring

educational program. The comparison of HCAHPS scores attained prior to and post caring education intervention for nurses has been used in caring educational programs as a method for evaluation (Desmond et al., 2014).

Summary

Section three is an overview of the components in the design and the development of the caring education program. The purpose of the project was to develop an educational program for nurses with the foundation of Watson's theory of caring. The caring education program was developed using evidence-based literature, the CFS-CPV results, Watson's theory of caring, and recommendations from the project team. Data collected from the CFS-CPV was analyzed and average mean scores were calculated for each statement on the survey. Average mean scores of less than five were added to the content of the education program. A comparison of the initial survey scores to the survey scores post education implementation was recommended to evaluate the desired outcomes of the education program. Additionally, it is recommended to evaluate HCAHPS scores in the care environment to compare scores prior to and after the implementation of the education program. The director of nursing education at the acute care hospital would implement the curriculum and evaluation plan.

Section 4: Findings and Recommendations

Introduction

The acute care hospital does not have an education program on caring practices in nursing for registered nurses. The practice problem at the acute care hospital was as follows: It was not clear what was generally known by the registered nurses in the medical surgical nursing unit about caring theory and caring nursing practices. Caring educational programs are supported by current literature and may bridge the gap between the science of caring knowledge and translation into caring nursing practices (Boev, 2012; Caruso et al., 2008; Curtis & Jensen, 2010; Desmond et al., 2014; Glembocki & Dunn, 2010, Herbst, 2008; Wolf, 2012). The practice-focused question was: Can a caring nursing educational program be developed from evidence-based practice literature? The purpose of this project was to design a caring educational program at the acute care hospital for registered nurses based on Watson's theory of caring (Watson, 1979). Nursing educational programs based on the science of caring in the acute care setting supports the incorporation of caring into these programs.

Sources of Evidence/Analytical Sources

I conducted the initial literature search electronically using the following databases: CINAHL, Medline, PubMed, and the Cochrane Library. Articles that I reviewed were less than 15 years old, unless they were considered classic research publications or articles. Terms used in the initial search included *caring, caring science, science of caring, nurse perceptions, nurse caring, caring attributes, Watson's theory of caring, caring nursing theories, carative factors, nurse caritas process, caring*

relationship, human caring, caring theory, knowing, and knowing the patient. I discarded articles if they did not contain relevant information related to an educational program on caring.

I subsequently performed an additional literature search in CINAHL, Medline, PubMed, and the Cochrane Library with a narrowed publication range of 2005 to 2015. I used the following search terms to narrow the search: *caring, caring science, education on caring, implementing caring theory, and nursing clinical practice and caring.* I also used Boolean phrases with the terms listed above to elicit a larger volume of articles.

I selected and critically appraised a total of 44 articles using a rapid critical appraisal process (Fine-Overholt, Melynk, Stillwell, & Williamson, 2010). I then sorted and grouped the articles into the following common themes that supported the development of the caring education curriculum: caring in nursing, concept of caring, knowing, caring theory in nursing, perception of caring by nurses, caring science in nursing education, caring in health care organizations, nurse patient relationship and caring, nursing education and caring, caring and holistic nursing, history of caring in nursing, caring behaviors, and measuring caring. I used the literature review to understand the concept of caring and associated attributes as perceived by both registered nurses and patients.

Findings

Analysis of Evidence Findings

A total of 37 registered nurses completed and returned the surveys of 44, an 84% return rate. The high sample size ($N = 37$) decreases the chance for sampling error and increases the representativeness of the sample (Grove et al., 2013). The sample size was homogenous for registered nurses that worked on the medical surgical nursing unit. The sample was heterogeneous for ethnic background (65% Filipino, 25% Latino, 10% Caucasian), and education level ranging from associate's degree to master's degree in nursing.

I calculated mean scores for each of the 20 statements on the survey and results ranged from 4.70 to 6.75 (Table 1). Statistical findings were verified by my preceptor. Higher mean scores of 5 and above indicate a greater perception of caring by nurses, whereas mean scores of less than 5 indicate lesser perception of caring by nurses (Desmond et al., 2014; Herbst, 2008; Nelson & Watson, 2012).

Table 1

Mean Average of CFS-CPV Survey Statements

CFS-CPV survey statements	Mean average score	*N*
I am very respectful of my patients' individual spiritual beliefs and practices.	6.75	37
I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.	6.64	37
I help support the hope and faith of the patients I care for.	6.62	37
I am responsive to my patients' readiness to learn when I teach them something new.	6.59	37
I work to meet the physical needs as well as the emotional or spiritual needs of the patient I care for.	6.59	37
When I teach patients something new, I teach in a way that they can understand.	6.56	37
I am able to establish a helping, trusting relationship with the patients I care for during their stay here.	6.56	37
I respond to each patient as a whole person, helping to take care of all their needs and concerns.	6.56	37
I encourage patient to speak honestly about their feelings, no matter what those feelings are.	6.56	37
Patients I care for can talk openly and honestly with me about their thoughts because I embrace their feelings, no matter what those feelings are.	6.56	37
The care I provide honors the patient's faith, instills hope and respects the patient's belief system.	6.43	37
I create an environment for the patients I care for that helps them heal physically and spiritually.	6.40	37
Every day that I provide patient care, I do so with loving kindness.	6.37	37
If a patient told me that they believed in miracles, I would support them in this belief.	6.27	37
As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.	6.10	37
I work to create healing environment that recognizes the patients' connection between body mind and spirit.	6.10	37
Overall, the care I give is provided with loving kindness.	6.05	37
I encourage patients to practice their own individual spiritual beliefs as part of self-care and healing.	4.97	37
I believe the health care team that I am currently working with solves unexpected problems really well.	4.86	37
Everybody on the health care team values relationships that are helpful and trusting.	4.70	37

Note. Scoring of items: 1 = *strongly disagree*, 2 = *disagree*, 3 = *slightly disagree*, 4= *neutral*, 5 = *slightly agree*, 6 = *agree*, 7 = *strongly agree.*

Synthesis of Evidence Findings

Descriptive statistics revealed that the highest scoring variable was perception of being respectful of patients' individual spiritual beliefs and practices (mean score of 6.75), whereas the lowest scoring variable was creation of a helping and trusting relationship (mean score of 4.70). The 20 statements of the CFS-CPV are associated to one of the 10 caritas processes (Table 2).

There were three statements on the CFS-CPV whose score was below 5 and were incorporated into the education curriculum lesson plan. The three statements below 5 from the CFS-CPV and associated caritas processes were (Table 2):

- Everybody on the health care team values relationships that are helpful and trusting (4.70). Relates to caritas process: Helping and trusting relationship**.**
- I believe the health care team that I am currently working with solves unexpected problems really well (4.86). Relates to caritas process: Decision making.
- I encourage patients to practice their own individual spiritual beliefs as part of self-care and healing (4.97). Relates to caritas process: Spiritual beliefs and practices.

There were no unanticipated limitations identified for this project. An unanticipated outcome for the project was a high rate of return of the CFS-CPV (84%).

Table 2

Ten Caritas Processes and Statements on the CFS-CPV

Caritas process	CFS-CPV survey statements
Practice loving kindness	Overall, the care I give is provided with loving kindness.
Decision making	I believe the health care team that I am currently working with solves unexpected problems really well.
Practice loving kindness	Every day that I provide patient care, I do so with loving kindness.
Decision making	As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.
Instill faith and hope	The care I provide honors the patient's faith, instills hope and respects the patient's belief system.
Teaching and learning	When I teach patients something new, I teach in a way that they can understand.
Instill faith and hope	I help support the hope and faith of the patients I care for.
Teaching and learning	I am responsive to my patients' readiness to learn when I teach them something new.
Spiritual beliefs and practices	I am very respectful of my patients' individual spiritual beliefs and practices.
Healing environment	I create an environment for the patients I care for that helps them heal physically and spiritually.
Spiritual beliefs and practices	I encourage patients to practice their own individual spiritual beliefs as part of self-care and healing.
Healing environment	I work to create healing environment that recognizes the patients' connection between body mind and spirit.
Helping and trusting relationship	I am able to establish a helping, trusting relationship with the patients I care for during their stay here.
Holistic care	I work to meet the physical needs as well as the emotional or spiritual needs of the patient I care for.
Helping and trusting relationship	Everybody on the health care team values relationships that are helpful and trusting.
Holistic care	I respond to each patient as a whole person, helping to take care of all their needs and concerns.
Promote expression of feelings	I encourage patient to speak honestly about their feelings, no matter what those feelings are.
Miracles	If a patient told me that they believed in miracles, I would support them in this belief.
Promote expression of feelings	Patients I care for can talk openly and honestly with me about their thoughts because I embrace their feelings, no matter what those feelings are.
Miracles	I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.

Implications

The IOM, *Crossing the Quality Chasm* (2001), supports patient-centered care that is responsive to patient and family member's preferences despite the differences in the perception of care between the patient and the nurse. Caring is a central component of the profession of nursing, yet nurses may lack the knowledge of caring science and translation into caring nursing practice. Informing nurses of the science of caring at the acute care hospital requires nursing leadership to develop and implement an ongoing caring education program for all registered nurses and newly hired registered nurses. Many health care facilities have benefitted from ongoing caring education programs (Dyess et al., 2010; Persky et al., 2008).

Implications for Practice

A caring education program has consistently been shown in the literature to improve the perception of caring for both the nurse and the patient in the acute care setting (Boev, 2012; Caruso, et al., 2008; Cook & Cullen, 2003; Curtis & Jensen, 2010; Desmond, et al., 2014; Glembocki & Dunn, 2010; Herbst, 2008; Wolf, 2012). Caring the essence of nursing practice can be provided through appropriate educational programs to inform and mentor nurses of the science of caring and to incorporate caring behaviors into nursing practice (Watson, 2008). This project introduces nurse educators to an education program that could improve nurses understanding of the science of caring and possibly improve patient outcomes.

Implications for Research

Additional study is needed on the benefits of a caring educational program in the acute care setting as evidenced by the gap between the science of caring knowledge and translation into caring nursing practices (Boev, 2012; Caruso, et al., 2008; Cook & Cullen, 2003; Curtis & Jensen, 2010; Desmond, et al., 2014; Glembocki & Dunn, 2010, Herbst, 2008; Wolf, 2012). Nurse education is both dynamic and fluid and should be evaluated on a regular basis. Caring, the essence of nursing and provides guidance to nursing practice can be developed, refined, and perhaps sustained and improved through research and evidence-based practice. Further study is needed to quantify the impact of caring education programs on nurses and patients in the acute care setting.

Implications for Social Change

The concept of caring and its relationship to nursing practice and the profession has been cited throughout the literature (Henderson, Van Epps, Pearson, James, Henderson, & Osborne, 2007; McCance, 2003; Watson, 2008). Patients and family members expect nurses to display caring behaviors while performing their duties in providing nursing care at all times. The caring educational program would bring social change to the acute care hospital by changing the culture of nursing and nursing practice. Introducing and providing nurses with a contextual understanding of nursing as a caring science through education may enable nurses to translate caring science into nursing practice and improve patient outcomes and satisfaction as measured by the HCAHPS scores.

Recommendations

Proposed Solution

The proposed solution was the design and development of a caring education program for registered nurses at the acute care hospital**.** The curriculum of the caring education program was derived from the CFS-CPV results, peer-reviewed literature, and any recommendations and suggestions from the project team. Designing and implementing a caring education program for nurses that is based on a caring theoretical foundation may bridge the gap between the science of caring knowledge and translation into caring nursing practice.

Content of the Curriculum

Rosswurm and Larrabee's model for evidence-based practice change provided guidance necessary to design and develop a caring educational program (Rosswurm & Larrabee, 1999). Watson's theory of caring provided the foundation for curriculum of the caring educational program. The content of the curriculum was developed from the CFS-CPV results and scholarly evidenced-based literature that supported the program. Content from the CFS-CPV included three statements that had an average mean score of less than 5**.** Average mean scores of less than 5 indicate lesser perception of caring by nurses (Desmond et al., 2014; Herbst, 2008; Nelson & Watson, 2012) and were included in the educational curriculum. The content from the literature review identified elements that should be incorporated into the educational curriculum and included overview of Watson's theory of caring, carative factors, the transpersonal caring relationship, caring consciousness, the caring occasion and results of the CFS-CPV (Appendix E).

Implementation

The acute care hospital will be responsible for implementing the nursing education program. The nursing education program will be four 4-hour days (Brown, 2011; Caruso et al., 2008; Desmond et al., 2014; Glembocki, et al., 2010; Sitzman, 2007; Valentine et al., 2014). The recommended findings included that the program format be a workshop that includes using visual aids, didactics, and discussions as a means of teaching the educational program to the nursing staff in hospitals (Brown, 2011; Caruso et al., 2008; Desmond et al., 2014; Glembocki, et al., 2010; Sitzman, 2007; Valentine et al., 2014).

Evaluation

A recommended short-term outcome would be administration of the CFS-CPV post education implementation and comparing the scores to the initial survey scores (Nelson & Watson, 2008). A recommended long-term outcome would be that HCAHPS scores attained in the care environment can be examined and compared to scores in a pre- and post-fashion after all registered nurses on the medical surgical nursing unit have completed the education program. Comparing HCAHPS scores attained prior to and post education intervention has been used as a method of evaluation of nursing education programs (Desmond et al., 2014).

Contribution of the Doctoral Project Team

Responsibilities of the Project Team Members

The process of working with a project team, the project leader needs to decide the composition of the team based on criteria such as level of expertise, the number of team members, and the role of the team members (Grove et al., 2013). The team consisted of administrative nurses from the medical surgical nursing unit, the nursing director, the nurse educator, myself, my preceptor, director of quality assurance, and the chief nursing officer.

The project team members for the educational project included the following specific duties. I served as the project team leader and administered the CFS-CPV to the nursing staff and developed the curriculum**.** The chief nursing officer of the acute care hospital promoted and lead efforts to implement the caring education program. The nurse educator provided input into the teaching methodology to be used for the educational program. My preceptor and myself provided data analysis of the CFS-CPV. The chief nursing officer was provided with the data analysis for review and shared the results with the medical surgical nursing director and the administrative nurses. I developed a draft of the caring education curriculum based on the data from the analysis and current scholarly literature. A caring education curriculum draft and informational packet was provided to the chief nursing officer (Appendix D). The chief nursing officer presented and discussed the curriculum draft with the medical surgical nursing director, director of quality assurance, and the administrative nurses for input and suggestions. The chief

nursing officer and nursing administrative team had no suggestions and the curriculum was approved.

Final Recommendations by the Project Team Members

The chief nursing officer was provided with a draft of the education curriculum for suggestions, revisions, and recommendations of the curriculum content. The chief nursing officer shared the draft of the educational curriculum, recommendations for implementation and evaluation with the project team members. There were no revisions, suggestions, or recommendations made and final approval of the curriculum was given by the chief nursing officer and the project team (Appendix E).

The chief nursing officer and the project team decided to implement the program over a period of time as to not interfere with staffing on the medical surgical nursing unit. The director of nursing education will coordinate the dates and times with the medical surgical director of nursing and the nursing staffing office in order to maintain staffing ratios on the medical surgical nursing unit. The director of nursing education will be the lead person to teach the classes, coordinate classroom space, obtain continuous education credits, and provide any necessary materials for each class. Currently, there are plans to extend the project beyond the DNP doctoral project by implementing the education program by the acute care hospital.

Strengths and Limitations of the Project

Strengths

Several strengths were identified for this education project. First, stakeholders and the administrative staff, and the project team were supportive of the project. Second, staff registered nurses were supportive of the project and participated as evidenced by an

eighty-four percent return rate of the CFS-CPV. Third, staff registered nurses completing and returning the survey represented day and night shifts that created a greater breath of data. Fourth, the acute care hospital is considering implementing the educational program and incorporating the program into the orientation process of registered nurses.

Limitations

Several limitations were identified for this project. First, registered nurses that participated in the project were only from the medical surgical unit of the acute care hospital, therefore; decreasing transferability to other nursing units. Second, the medical surgical nurses may have differing ideas of caring practices in nursing. Third, conflict with work schedules and vacations may have interfered with nurses' participation in the CFS-CPV. Fourth, the ethnic background and educational level of the registered nurses on the medical surgical nursing unit may have different notions of the concept of caring. Similar limitations were noted in other caring education evidence based literature (Caruso, Cisar, & Pipe, 2008; Dyess et al., 2010; Persky et al., 2008).

Recommendations for Future Projects

I recommend conducting an ongoing literature review of all evidence-based research on the concept of caring and caring attributes to update the educational program on a semi-annual basis. A second recommendation is to administer the CFS-CPV monthly to newly hired registered nurses and ancillary personnel to establish educational learning needs on caring. A third recommendation is to administer the CFS-CPV to all existing ancillary department personnel to establish caring educational learning needs for all hospital personnel. Finally, I recommend that the acute care hospital evaluate

HCAHPS scores on a quarterly basis after the implementation of the education program and compare the scores to previous quarters (Desmond et al., 2014).

Section 5: Dissemination Plan

Dissemination Plan

I presented the Design and Development of an Educational Intervention on Nurse Perceptions of Caring to the chief nursing officer. This included the curriculum, results of the CFS-CPV, and recommendations of implementation and evaluation of the program (see Appendix D). The chief nursing officer preferred to take the opportunity to present the information to the project team and administrative staff. There were no revisions or suggestions to the curriculum and the chief nursing officer gave final approval. The chief nursing officer will consider implementing the program in the future. In addition, I offered my assistance to work with the director of nursing education to update orientation for new hires by inclusion of the education program.

I plan to develop a poster presentation for the Association of California Nurse Leaders (ACNL) to be presented at the annual ACNL conference in 2018. Members of ACNL include nurse executives, nursing directors, nurse practitioners, clinical nurse specialists, directors of quality assurance, and university nurse educators. I also plan to develop a manuscript for either the *Journal of Nursing Staff Development*, the *Journal of Nursing Scholarship*, the *International Journal for Human Caring*, the *Journal of Nursing Administration,* the *American Nurse Today*, the *Journal of Clinical Nursing*, and the *International Journal of Nursing Practice*. Nurse educators, clinical nurse specialists, nursing administrators, nursing faculty, nursing directors of quality assurance, and staff nurses are the target audiences for these nursing journals.

Analysis of Self

Role as a Practitioner

Developing the caring education program has increased my knowledge of translating evidenced-based practices in caring to clinical practice. It has expanded my skills of evaluating evidence on caring science in the literature to generate nursing practice change and apply that knowledge to clinical nursing practice s. I have gained deeper insights that help to inform my practice in clinical areas. I have become more informed that my clinical practice is from a philosophical and theoretical base. This project has helped me to have a deeper understanding of the constructs of caring that inform my clinical practice as a practitioner.

Role as a Scholar

Developing the caring education program has expanded my role as a nurse scholar in the areas of clinical scholarship, critical inquiry, and research. Translating evidence based practice into nursing practice is the core of clinical scholarship. The role of a clinical scholar in advanced practice has allowed me to integrate scholarship with clinical practice. Integration of evidence with clinical practice is purposeful and systematic. I have expanded my role as a clinical scholar by using a systematic approach and process that allows the implementation and evaluation of findings that could possibly change or improve nursing practice and patient outcomes.

Role as a Project Manager

As a project manager, I have learned that in order for a project to be effectively implemented, the project manager must select the team members that will assist and

positively contribute in implementing the project. My project team consisted of the chief nursing officer, my preceptor, director of medical-surgical nursing, nurse educator, director of quality assurance, and the administrative nurses. Team members that have expertise ability, marketing ability, data collection, and analytical abilities, strengthen the project in being successful (Grove et al., 2013). I have learned to develop a timeframe, such as developing a Gantt chart to effectively track tasks that need to be accomplished. The Gantt chart was useful in that I was able to adjust the timeframes for unforeseen variables hindering the progression of the project.

Completion of the Project: Challenges, Solutions, and Insights

Completion of the educational program for the acute care hospital presented challenges along the way. One challenge was scheduling meetings with the project team members in which members could attend the meeting. A solution was to assign those members attending the meeting to brief those members that could not attend. Another challenge was that my original preceptor accepted another job and left the acute care hospital thus requiring searching for another preceptor that met the requirements of a preceptor as set forth by Walden University.

Summary

An educational program formulated and based on Watson's theory of caring improves quality of nursing care to our patients by providing a practice structure with positive patient outcomes (Watson, 2008). Watson's theory of caring has been used as a guide for advancing nursing practice and nursing education (Watson, 2008). Nurse researchers have demonstrated in the literature that by adopting a caring theory in an

acute care hospital may result in transformative changes in the profession of nursing and in the practice environment (Dyess et al., 2010).

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Appendix A: Letter of Permission

Drs. Nelson and Watson April 26, 2015

My name is John Norris RN, and I am currently attending Walden University as a graduate student working towards attaining a Doctor of Nursing Practice degree. My capstone project is developing an educational program with Watsons' Theory of Caring as the curriculum foundation. I read that this survey is in the public domain and wanted to inform you both that I will be using this survey tool in my scholarly project.
I would appreciate an email from you acknowledging my request so that I may incorporate it into my written project appendices.

Thank you so much,
John Norris

Hello John, April 26, 2015
Good to hear from you and of your use of the CFS-CPV. I should tell you we had another manuscript just accepted in the International Journal of Human Caring. Let me now if you'd like a copy of that manuscript. I do not know the issue yet as I just received the acceptance letter yesterday. Please proceed as you deem fit. If you could let us know your findings, that would be wonderful so we can continue to network within the caring science community and grow our knowledge collaboratively. Let us know if we can support you in any way.

Kind regards,
John

John W. Nelson, PhD, MS, RN
President of Healthcare Environment
Facilitator for the Caring International Research Collaborative (CIRC),
a research community of Sigma Theta Tau International (STTI)

<jeanwatson
To: John Nelson

Cc: John Norris
Re: Caring Factors Survey-Care Provider Version

Dear John April 27, 2015

Thanks for update and your research plans. Appreciate knowing of your studies for DNP with focus on caring!
Congratulations and all good wishes for success!
I think we both will be interested in outcome.
In loving kindness,
Jean

Sent from my iPhone

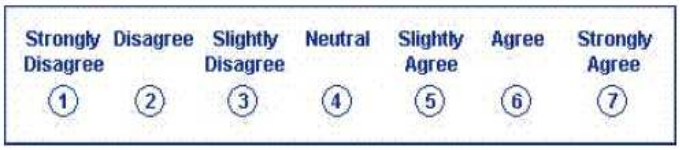
Appendix B: Caring Factor Survey-Healthcare Provider Version

Caring Factor Survey – Care Provider Version (CFS – CPV)
Directions to care provider:
This is a survey that measures your perception of the care you are providing for the patients who are under your care. It would be very helpful if you would respond to each of the 20 statements noted below about how you feel regarding the care you are currently providing to patients. The information you provide by completing this survey will help me understand your perception of providing care more clearly. If you are able to respond to this brief survey, I thank you for your time and consideration. If you are not able to respond, I understand and respect your decision. If you do want to participate in this survey please read the following instructions and respond to the 20 statements.

Thank you for our time and consideration in helping us understand the process of caring for patients!

Instructions: Please read each statement as it relates to you as a care provider to patients. For each question, you will be asked to indicate how much you agree or disagree with the statement. Please mark your responses by completely filling in the circle that best represents your opinion. For example, if you strongly agree with the statement, you fill in the circle under "Strongly Agree."

1



1. Overall, the care I give is provided with loving kindness.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

2. I believe the healthcare team that I am currently working withsolves unexpected problems really well.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

3. Every day that I provide patient care, I do so with loving kindness.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

4. As a team, my colleagues and I are good at creative problemsolving to meet the individual needs and requests of our patients.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

5. The care I provide honors the patient's faith, instills hope andrespects the patient's belief system.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

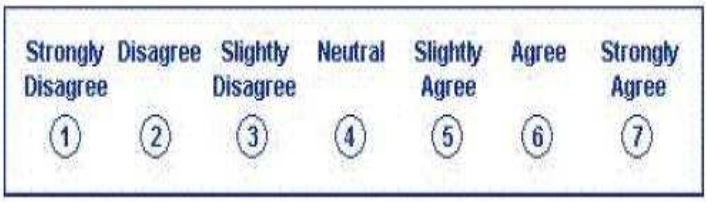
6. When I teach patients something new, I teach in a way that theycan understand.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

7. I help support the hope and faith of the patients I care for.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

2



8. I am responsive to my patients' readiness to learn when I teachthem something new.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

9. I am very respectful of my patients' individual spiritual beliefs andpractices.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

10. I create an environment for the patients I care for that helps themheal physically and spiritually.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

11. I encourage patients to practice their own individual spiritual beliefsas part of self-caring and healing.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

12. I work to create a healing environment that recognizes the patients'connection between body, mind, and spirit.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

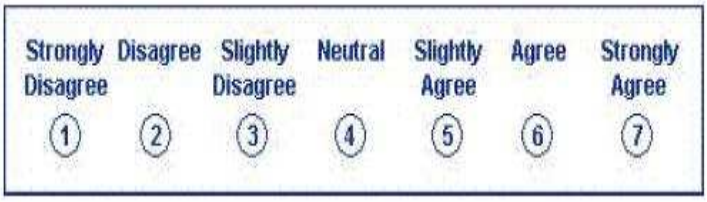
13. I am able to establish a helping-trusting relationship with thepatients I care for during their stay here.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

14. I work to meet the physical needs as well as the emotional or spiritual needs of the patients I care for.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

3



15. Everybody on the healthcare team values relationships that arehelpful and trusting.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

16. I respond to each patient as a whole person, helping to take care ofall of their needs and concerns.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

17. I encourage patients to speak honestly about their feelings,no matter what those feelings are.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

18. If a patient told me that they believed in miracles, I would supportthem in this belief.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

19. Patients I care for can talk openly and honestly with me about theirthoughts because I embrace their feelings, no matter what those feelings are.

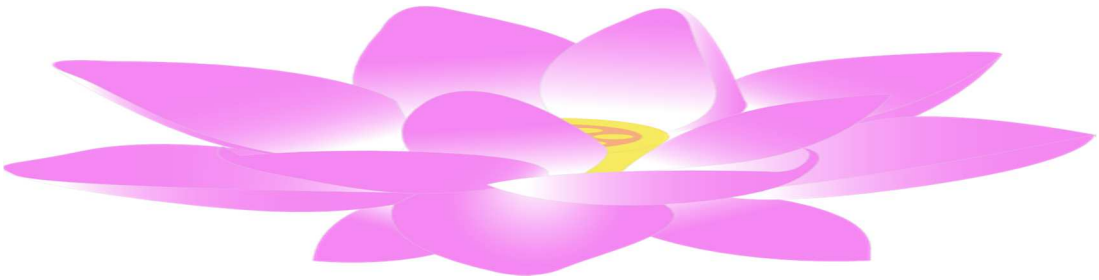
1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

20. I am accepting and supportive of patients' beliefs regarding ahigher power if they believe it allows for healing.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

Appendix C: Educational Flyer

CARING



Registered Nurses on the medical-surgical floor are invited to participate in a project to design and build an educational program on caring. You can be part of my doctoral project by agreeing to and completing the Caring Factor Survey-Care Provider Version. Data from the survey will be used to build and design an educational curriculum on caring for Registered Nurses. Completion of the survey should take 15 minutes or less.

When: April 25, 28,
May 2, 3, 5, 9, 10, 12

Where: Board Conference Room/Nursing Lounge

Times: 0530-0700 & 1730-1930

Participation is voluntary and all surveys are anonymous and kept confidential

Contact Person: John Norris RN (562-900-3378)

Appendix D: Information Packet for Nursing Administration

Curriculum for the Caring Education Workshop

LEARNING OBJECTIVES:

1. Describe the components of Watson's caring theory.
2. Describe clinical application of Watson's caring theory into clinical practice.
3. Describe the Carative Factors as they relate to your nursing practice.
4. Describe the process of establishing a Transpersonal Caring Relationship with patients

EVALUATION STRATEGIES:

1. Pre-and Post CFS-CPV
2. HCAHPS Scores

Curriculum Content

LEARNING ACTIVITY CONTENT	INSTRUCTIONAL STRATEGY	TIME
Overview of Watson's Theory of Caring	Didactic Discussion	30 minutes
Carative Factors	Didactic Discussion	1 hour
Transpersonal Caring Relationship Caring Consciousness Caring Occasion Concept of Knowing	Didactic Discussion Role Playing Story Telling Case Study	2 hours
Results of the CFS-CPV with scores less than 5:	Discussion	30 minutes
Helping and Trusting Relationship Decision Making Spiritual Beliefs and Practices	Discussion Discussion Discussion	

Mean Average of CFS-CPV Survey Statements

CFS-CPV Survey Statements	Mean Average Score	*N*
I am very respectful of my patients' individual spiritual beliefs and practices	6.75	37
I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.	6.64	37
I help support the hope and faith of the patients I care for.	6.62	37
I am responsive to my patients' readiness to learn when I teach them something new.	6.59	37
I work to meet the physical needs as well as the emotional or spiritual needs of the patient I care for.	6.59	37
When I teach patients something new, I teach in a way that they can understand	6.56	37
I am able to establish a helping, trusting relationship with the patients I care for during their stay here.	6.56	37
I respond to each patient as a whole person, helping to take care of all their needs and concerns	6.56	37
I encourage patient to speak honestly about their feelings, no matter what those feelings are.	6.56	37
Patients I care for can talk openly and honestly with me about their thoughts because I embrace their feelings, no matter what those feelings are.	6.56	37
The care I provide honors the patient's faith, instills hope and respects the patient's belief system	6.43	37
I create an environment for the patients I care for that helps them heal physically and spiritually	6.40	37
Every day that I provide patient care, I do so with loving kindness.	6.37	37
If a patient told me that they believed in miracles, I would support them in this belief	6.27	37
As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.	6.10	37
I work to create healing environment that recognizes the patients' connection between body mind and spirit	6.10	37
Overall, the care I give is provided with loving kindness	6.05	37
I encourage patients to practice their own individual spiritual beliefs as part of self-care and healing	4.97	37
I believe the health care team that I am currently working with solves unexpected problems really well	4.86	37
Everybody on the health care team values relationships that are helpful and trusting.	4.70	37

Scoring of Items: 1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Slightly Disagree*, 4= *Neutral*, 5 = *Slightly Agree*, 6 = *Agree*, 7 = *Strongly Agree*

Ten Caritas Processes and Statements on the CFS-CPV

Caritas Process	CFS-CPV Survey Statements
Practice loving kindness	Overall, the care I give is provided with loving kindness
Decision making	I believe the health care team that I am currently working with solves unexpected problems really well
Practice loving kindness	Every day that I provide patient care, I do so with loving kindness.
Decision making	As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.
Instill faith and hope	The care I provide honors the patient's faith, instills hope and respects the patient's belief system
Teaching and learning	When I teach patients something new, I teach in a way that they can understand
Instill faith and hope	I help support the hope and faith of the patients I care for.
Teaching and learning	I am responsive to my patients' readiness to learn when I teach them something new.
Spiritual beliefs and practices	I am very respectful of my patients' individual spiritual beliefs and practices
Healing Environment	I create an environment for the patients I care for that helps them heal physically and spiritually
Spiritual beliefs and practices	I encourage patients to practice their own individual spiritual beliefs as part of self-care and healing
Healing environment	I work to create healing environment that recognizes the patients' connection between body mind and spirit
Helping and trusting relationship	I am able to establish a helping, trusting relationship with the patients I care for during their stay here.
Holistic care	I work to meet the physical needs as well as the emotional or spiritual needs of the patient I care for.
Helping and trusting relationship	Everybody on the health care team values relationships that are helpful and trusting.
Holistic care	I respond to each patient as a whole person, helping to take care of all their needs and concerns
Promote expression of feelings	I encourage patient to speak honestly about their feelings, no matter what those feelings are.
Miracles	If a patient told me that they believed in miracles, I would support them in this belief
Promote expression of feelings	Patients I care for can talk openly and honestly with me about their thoughts because I embrace their feelings, no matter what those feelings are.
Miracles	I am accepting and supportive of patients' beliefs regarding a higher power if they believe it allows for healing.

Implementation Recommendations

- The acute care hospital will be responsible for implementing the nursing education program.
- The nursing education program will be four 4-hour days. The literature review suggests that the program format be a workshop that includes using visual aids, didactics, and discussions as a means of teaching the educational program to the nursing staff in hospitals.
- The director of nursing education will coordinate the dates and times with the medical surgical director of nursing and the nursing staffing office in order to maintain staffing ratios on the medical surgical nursing unit.
- The director of nursing education will be the lead person to teach the classes, coordinate classroom space, obtain continuous education credits, and provide any necessary materials for each class.

Evaluation Recommendations

- A recommended short-term outcome would be administration of the CFS-CPV post education implementation and comparing the scores to the initial survey scores.
    - A recommended long-term outcome would be that HCAHPS scores attained in the care environment can be examined and compared to scores in a pre-and post-fashion after all registered nurses on the medical surgical nursing unit have completed the education program.

- Comparing HCAHPS scores attained prior to and post education intervention has been used as a method of evaluation of nursing education programs.

Appendix E: Curriculum for the Caring Education Workshop

Curriculum for the Caring Education Workshop

LEARNING OBJECTIVES:

1. Describe the components of Watson's caring theory.
2. Describe clinical application of Watson's caring theory into clinical practice.
3. Describe the Carative Factors as they relate to your nursing practice.
4. Describe the process of establishing a Transpersonal Caring Relationship with patients

EVALUATION STRATEGIES:

1. Pre-and Post CFS-CPV

Curriculum Content

LEARNING ACTIVITY CONTENT	INSTRUCTIONAL STRATEGY	TIME
Overview of Watson's Theory of Caring	Didactic Discussion	30 minutes
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Transpersonal Caring Relationship Caring Consciousness Caring Occasion Concept of Knowing	Didactic Discussion Role Playing Story Telling Case Study	2 hours
Results of the CFS-CPV with scores less than 5: Helping and Trusting Relationship Decision Making Spiritual Beliefs and Practices	Discussion Discussion Discussion Discussion	30 minutes