

## **Caring in Action: The Patient Care Facilitator Role**

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### **Abstract**

**The downsizing movement left fractures in the healthcare system for patients, nurses, and healthcare providers. To heal the fractures, nurses at the Baptist Hospital of Miami developed the patient care facilitator (PCF), a clinical leadership role for nurses within a smaller area of patient responsibility (12-bed hospital), to provide caring professional nursing practice for both patients and staff. This article describes the multimethod research done to evaluate the impact of the role on continuity of care for patients and caring behaviors of nursing staff. All methods, both qualitative and quantitative, converged and clearly demonstrated the value of the PCF in providing continuity of care from a caring framework.**

*Key Words: Care delivery model, caring, continuity of care, new role, nursing administration, patient care facilitator, 12-bed hospital, clinical nurse leader, Watson's philosophy, theory of caring*

As the 21st century dawned, nurses faced the challenge of trying to heal wounds left in the aftershock of fragmented care resulting from the downsizing movement of the 1990s. Nursing staff felt disgruntled and pressed to do more with less while patients felt less than happy with their care. Nurses at the Baptist Hospital of Miami (BHM) recognized the need to create healing environments for both the patients and nurses. Because caring serves as the core concept for such healing environments, nurses sought ways to enhance caring practices at their hospital. In the summer of 2001, the Nurse Governance Council at Baptist Hospital adopted Jean Watson's philosophy and theory of caring to guide nursing practice. At about the same time, a new nursing role, the patient care facilitator (PCF), started on just one nursing unit as one way to enact professional nursing practice that exemplified both caring and continuity of care. As a result of redesign efforts to streamline and create more cost-effective care, continuity of care had faded.

During the redesign of the 1990s nurses took on additional responsibilities normally carried out by other departments. Actual nursing care time lessened as additional responsibilities increased. Nursing schedule patterns further compounded these problems because nurses now worked part time, as well as flexible shift options, including 12-hour shifts. Often patients saw many different caregivers during their stay. Krogstad, Hofoss, and Hjortdahl (2002) reported that patients highly appreciate "front stage" continuity where they see the same doctor or nurse day after day. They indicate that continuity of care for patients needs the most improvement in hospital care today.

Jean Watson's (1985, 1999) philosophy and theory of caring provides a way to blend the highly technical, cost conscious healthcare environment of today with the more human practices of caring. Her carative factors undergird the model of care described in this article. Early on in the development of the PCF role, caring was identified as one of the primary needs of patients.

Caring underpins continuity of care while continuity of care reinforces caring. This very important notion provides the cornerstone for the PCF role in the 12-bed hospital model of care; a model that places patient needs at the center of the delivery system where they belong. The 12-bed hospital does not mean a small stand-alone hospital but rather means that the PCF acts as the CEO for a small group of patients, usually 12 in number.

The PCF is an experienced nurse who provides leadership for a team of nurses assigned geographically in one segment of the patient care center (approximately 12-16 patients) and whose primary job is to know each patient in this area, serving as their advocate during the course of their stay. The PCF acts as liaison for physicians, nurses, and other members of the healthcare team involved in each patient's care. While acting to coordinate all care the patient receives, the PCF becomes the one consistent person the patient and family see daily during the course of their stay. PCFs assure continuity of care. In addition, care team members can concentrate on the many tasks associated with care delivery, while the PCF coordinates more complex and time consuming care activities.

Before instituting the PCF role on the whole unit, a pilot study was conducted. In August 2000, a single experienced, expert clinical nurse began to enact the role. Nurse administrators and unit staff carefully monitored the effectiveness of the role. Clark (2004) fully describes the evolution of the 12-bed model and PCF role in her *Nursing Administration Quarterly* article. A research team formed to evaluate the effects of the PCF role in 2001. This article describes that research. The reader should also know that the PCF role as CEO of a 12-bed hospital now pervades the Baptist Hospital of Miami.

### **Literature Review**

A review of the literature conducted as the PCF role began to develop uncovered many articles, none of which fully applied to the role as described in this article. Of the articles reviewed, case management as a delivery system dominated and continues to dominate the literature. The overarching concepts revealed in the case management model of care described the case manager as clinical expert who possesses good communication skills, while coordinating care within specific diagnosis-related groups. The case manager assists with discharge planning thus reducing costs through case management (Anderson-Loftin, 1997; Brubakken, Janssen, & Ruppel, 1994; Huggins & Lehman, 1997).

In response to pressing needs for new ways to provide care, several initiatives appeared in more recent nursing literature. The American Association of Colleges of Nursing (AACN, 2005) clinical nurse leader (CNL) role closely dovetails many of the tenets underpinning the PCF role described here. The CNL emphasizes care across the continuum, focusing on care throughout the inpatient, outpatient, and community settings. According to the AACN, the clinical nurse leader was developed to be a leader in the healthcare delivery system across all settings where healthcare is delivered, not just the acute care setting. The role is admirable in its wide sweeping focus on clinical leadership in the whole of the healthcare continuum. Drenkard (2004) summarized the CNL role in a recent *Journal of Nursing Administration* article. Both sources made obvious that the CNL role shares many similarities to that of the PCF. For example, neither role includes administration or management. The CNL designs, implements, and evaluates client care by coordinating, delegating, and supervising the care provided by the healthcare team, including licensed nurses, technicians, and other health professionals. One way the roles differ is that the CNL holds accountability for the care outcomes of clinical populations, whereas, PCFs are accountable for the small group of patients in their 12-bed hospital. The CNL role

demonstrates altruism but the PCF role takes this a step further, turning care for the patient into a way to fully exemplify caring by the nurse. To become a PCF, one must demonstrate expertise at bedside caring as well as clinical expertise, whereas the CNL gains their experience as part of their educational program while under the mentorship of an identified CNL. How this clinical experience occurs for the new CNL remains to be seen. Hopefully research will demonstrate just where in the novice to expert (Benner, 1984) journey the CNL falls.

Watson and Foster's (2003) attending nurse caring model shares similarity to the PCF. Inspiration for the model evolved from wanting more than a "care delivery system driven by technology, diagnosis and treatment of acute illness, and product line management" (p. 361). The attending caring nurse (ACN) moves "away from traditional hospital structures and their routinized, industrial practices." (p. 361). The ACN exemplifies caring-healing. ACNs establish and sustain "a continuous, caring relationship with patients/families" (p. 363). It shares this characteristic with the PCF. The ACN also oversees and assures "comprehensive care planning and in some instances directly carries out the therapeutic regime plan related to the caring-healing modalities of nursing" (p. 363). Other similarities to the PCF involve "...creating plans for direct communication with other nurses, physicians and team members to assure continuity...The ACN is responsible for oversight of this comprehensive plan of caring and healing, 24 hours a day" (p. 365). The ACN and PCF may differ in that the PCF is always an experienced nurse whose responsibility is to provide leadership to a team of nurses assigned geographically to one segment of a patient care center and whose primary job is to know each patient in this geographic area. In any case, both roles demonstrate strong links to Watson's work on caring. Mustard's (2002) nurse hospitalist role also shares characteristics with both the ACN and PCF, but does not depend on caring theory as a base.

### **Purposes for the Research**

As plans progressed for the new PCF role, a research team identified research strategies to evaluate the effectiveness of the model. The team consisted of nurse administrators responsible for creating the role, PCFs, nurse clinicians, and nurse researchers. After much deliberation, the team agreed that the purpose of the research was to explore the impact of the nursing care delivery model changes on continuity of care since institution of the PCF role. Watson's (1985, 1999) philosophy and theory of caring guided the research efforts. A second research purpose was to determine the effects of the PCF role on caring by nurses.

### **Method**

#### ***Research Design***

The research design encompassed diverse research strategies with the expectation that triangulated quantitative and qualitative approaches would yield stronger results than a single research approach. Because the PCF was a new role and many of the questions the team wanted answered did not fit into existing instrumentation with known reliability and validity, the team chose to utilize qualitative approaches to generate some of its data in the context of discovery. Where caring theory clearly applied, the team chose to use a nonexperimental survey approach allowing for determination of the effects of the PCF role on caring behaviors. Caring behaviors were measured through use of the Caring Behaviors Assessment (Cronin & Harrison, 2002), an instrument with known psychometric properties. The use of multiple approaches allowed for triangulated results from different research approaches to become known.

To protect the interests of all parties participating in the research, the study received BHM Research Council and administrative support, along with Institutional Review Board approval.

Action Research (2001) guided the whole of the study as an overarching research framework. Such a framework allowed for the hospital to use data and study results as they emerged from the study. In fact, while the study moved toward completion, the PCF/12-bed hospital model spread throughout the hospital. Shortly after the study began, two more nursing units that were starting the PCF model on their units joined the study. For these two units, only two parts of the study occurred: patients received the same questionnaires being used in the rest of the study. The interdisciplinary staff from these two units also received the same open-ended questionnaires as the staff from the original unit in the study. Thus, three nursing units participated in the study.

### ***Data Sources and Analytic Strategies***

Open-ended questionnaires with demographic questions were administered to interdisciplinary staff members from three nursing units. Respondents included nurses in all roles, physicians, and ancillary professional and nonprofessional staff. Demographic information included role, educational level, and their employment at the hospital. Respondents were also asked to indicate whether or not they had worked with a PCF. If they indicated they had worked with a PCF, they were asked four questions:

1. How does this role affect your practice?
2. What have been the effects of the PCF on patient care?
3. What have you heard patients say about care on this unit?
4. What else would you like for the research team to know?

These data were grouped by role and question. Comments to each question were examined for themes.

Five members of the research team conducted in-depth qualitative interviews of 27 patients and staff. The researchers used a modified phenomenological approach as a way to explore experiences with the new role. Thorne, Kirkham, and MacDonald-Emes (1997) provided guidance in the use of interpretive description to modify the phenomenological approach. To legitimize the methodological modification, Thorne, Kirkham, and O'Flynn-Magee (2004) state:

The past decade has witnessed remarkable evolution within qualitative health research as scholars have moved beyond initial adherence to the specific methods of phenomenology, grounded theory, and ethnography to develop methods more responsive to the experience based questions of interest to a practice-based discipline.

All staff groups, including registered nurses, clinical partners, administrative partners, nurse administrators, clinicians, PCFs, physicians, and ancillary professional staff, as well as patients, participated in the interviews. Insofar as possible, two interviews per identified category of personnel occurred. One research team interviewer conducted interviews of two Spanish-speaking patients in their own language. In keeping with the phenomenological tradition of interviewing, the interviewers were "trained" in interviewing to assure stability in the data generated. Each interviewer opened the interview with an open-ended comment geared to generate whatever the interviewee thought was important about the care on this unit. Interviewers specifically did not ask about the PCF role because an assumption underlying this mode of data generation was that if the PCF role were important to care, interviewees would say so in the process of describing care on this unit. For example, those who interviewed patients might say something like, "I am interested in knowing about the care you received on this unit.

Please begin with whatever you would like to share about the care you received.” Interviewers modified this initial comment according to whom they interviewed. They took their cues about how to proceed throughout the interview by what ensued during the interview. All interviews were audiotape recorded. After taped data were transcribed, each interviewer identified themes within their respective interviews. Data analysis then diverged from more traditional phenomenological processes in that analysis occurred in the context of a group rather than a single researcher. The five interviewers developed a thematic structure to represent data from all the interviews. Interviewers left this session to further reflect on the data and the themes generated, with the added task of identifying interview material representing each of the identified themes. When the group came together for the last time, three more themes were identified along with the unity of meaning (Ray, 1985).

Two focus groups, day-evening and evening-night staff RNs, from the original nursing unit were conducted. The following five questions/comments guided focus group data generation:

1. Please tell us what you think about the PCF role.
2. How has working with a PCF affected your practice?
3. How do you see care on this unit delivered with the PCF role as different from other units where you work or have worked?
4. How has the PCF role affected continuity of care on this unit?
5. How can this unit improve care?

After audiotaped data were transcribed, the focus group leader grouped and categorized content according to questions and groups.

A day prior to discharge from the hospital, the Caring Behaviors Assessment (CBA) tool (Cronin & Harrison, 2002) with specific questions about the effects of the PCF role and other specific demographics was administered to patients from the three nursing units participating in the study. Cronbach’s alpha, a measure of internal consistency, for the seven CBA subscales designed to measure Watson’s carative factors included:

Humanism/Faith-hope-sensitivity	0.84
Helping/Trust	0.76
Expression of positive/Negative feelings	0.67
Teaching/Learning	0.90
Supportive/Protective/Corrective action	0.79
Human needs/Assistance	0.89
Existential/Phenomenological	0.66

Cronin and Harrison (2002) also indicated that the tool demonstrates content validity, as determined by four experts in Watson’s caring theory. Because the hospital serves many patients who speak only Spanish, the research team received permission from Cronin and Harrison to translate the CBA questionnaire into Spanish. The full questionnaire, including demographics, was translated into Spanish, then back-translated into English, with differences between the two translations resolved. The Spanish version of the instrument was then given to a translator who certified it was a correct translation. Whether or not patients had a PCF formed the independent variable for grouping data. Whether or not patients felt ready to go home, whether or not patients believed everyone knew all about their care, and the mean carative factors subscale scores on the CBA were selected as the dependent variables. Demographic data and non-CBA questions were analyzed by descriptive statistics. Chi-square was used to analyze dichotomous data and t-tests were used to analyze the Likert-scaled CBA subscales.

## **Results**

Response rates from the three nursing units involved in the study may be viewed in Table 1. Briefly, 559 patient questionnaires, 123 staff questionnaires, 27 in-depth individual interviews, and 2 focus groups comprised data for this study.

T-tests for independent means established that patients who indicated they had a PCF had significantly higher means ( $p > .01$ ) on each of the carative factor subscales from the CBA than those who said they did not have a PCF (Table 2). Patients also perceived that everyone knew all about their care when they had a PCF at a significantly greater rate (Chi Square:  $p = .000$ ) than if they did not have a PCF. This finding clearly supports that having a PCF increases continuity of care for patients. In addition, patients who had a PCF for their care said they felt ready to go home at a significantly higher rate than did those who did not have a PCF (Chi Square,  $p = .026$ ). All these statistical results support positive outcomes stemming from having a PCF to coordinate their care, i.e., patients perceived more caring behaviors on the parts of staff; believed that everyone on the team knew all about their care; and felt more ready to go home at the time of their discharge.

All three sets of qualitative data, staff open-ended questionnaires, focus groups, and individual interviews converged around the following common themes (Figure 1). All interviews contained themes of teamwork, continuity, relationship, helping, competence, and communication. Caring resides in the core of the model and forms what the research team termed “the soul of the PCF role.” Surrounding this center are themes of love, caregiving, and emotional connection. This model requires further explanation for the reader to fully understand its meaning.

### **The Soul of the Role**

PCFs feel a strong connection with patients and their families. In fact, patients often make the PCFs feel as if they are a part of the patient’s family. When there is a PCF caring for them, patients and families feel very satisfied, they know that someone from the nursing staff cares about them. They feel personally cared for. One of the most powerful expressions of the soul of the role is that nurses who are PCFs feel the PCF role brings out their passion about being a nurse. This passion for nursing and the caring that is expressed surfaced as a constant theme in the interview process. The power of the role expressed itself through the connections these nurses make with the patients for whom they care. The trust patients and families give to the PCF becomes just one of the rewards the PCFs receive from their role.

Several of the PCFs expressed that while being a PCF is usually a positive experience, at times, they feel vulnerable when connecting with the patients/families. They felt that at times it was hard to separate their emotions from those of the ones they care for. This seems to mean that PCFs provide nursing care with their whole selves. Sometimes patients and families demand so much from the PCFs that they have to find ways to replenish their energy; there is no wall to protect them. One interviewee remarked that most PCFs feel they act as shields for the patient; they are patient protectors. With all of this comes taking risks, including the possibility of losing relationships with physicians and, at other times, with administrators because at times PCFs have to stand up for the patient, advocating for them in their time of need. Sometimes doing so puts them at odds with those who represent power in the system. When discord surfaces involving the plan of care, the patient needs triumph. Sometimes this puts the PCF at odds with the system or other team members. The PCF, however, is empowered by the system to act on behalf of the

patient and family. PCFs exhibit highly developed interpersonal skills and thus, usually broker solutions acceptable to all parties, all in the service of the patient.

Patients continue to feel connected to their PCFs after they are discharged. They may call them with questions or just to check in. If they are readmitted to the hospital, they consistently ask to be assigned where their PCF works; they want their PCF to stay with them. If readmitted, patients must be assigned to a different unit than where their PCF works, they may ask for their PCF to visit and/or assist with their care.

Thus, the soul of the PCF role is caring with all of its vulnerabilities and rewards for all touched by its power.

### ***Love, Caregiving, and Emotional Connection***

Love, caregiving, and emotional connection are strong themes surrounding the soul of the role. These themes both strengthen and give definition to the core soul of the PCF role. Because the team at first focused on the more traditional elements inherent in the data, it took in-depth analysis to understand that what all the interviews pointed to was the emotional core of the role: emotional connection, love, and caregiving for all who touched the 12-bed sphere of the PCF. Watson (2003) speaks of the notion of love as a part of caring when she states:

So, within this framework of caring and love, we now have a new call to bring us back to that which resides deep within us, and intersects with the focus of this time and place to uncover the latent love in our caring work as well as connect us with contemporary philosophies that invite love and caring through our ethics of being-becoming...Perhaps it is love that underpins and connects us through our metaphors of facing and holding another dimension as to how to sustain our humanity at a deeper level at this point in human history. (p. 3)

It took courage for the research team to honestly name that which gives life to the soul of the PCF role; love, caregiving, and emotional connection.

The caring soul of the PCF role expresses itself through its many facets, those seen in the outer band of Figure 1. These are the more traditional elements one finds in job descriptions. They are the usual elements of a role. They surfaced in first-level analysis. Yet these elements came to life when given expression through the role's caring center. The PCF role allows for full expression of the caring/healing nurse. Each of these themes (Figure 1) is described in the following sections.

### ***Teamwork***

Teamwork provides one of the hallmarks of the role. The PCF acts as the hub of the team, the conductor of all team activities. All of the qualitative data sources highlighted teamwork. One of the PCFs gave an example, when she spoke about a Clinical Partner (CP) who noticed something wrong with a patient. The CP, who felt a valued member of the team, did not rest until the PCF assessed the patient. The patient was about to go into respiratory distress and the care team was able to avoid cardiac arrest for the patient because of the persistence of this important team member. How does the PCF create a team? As one PCF described it, at the core she respects individuals by recognizing their human needs for care and respect. She does this for each team member, from physician to clinical partner. Physicians, in particular, value the PCF. Once physicians learn to trust in the expertise of the PCF, they feel gratitude that "there is one more pair of eyes watching out for the patient." Schmidt (2003) captured this notion in the category, "watching over," as a nursing role in his grounded theory study of patients' perceptions

of nursing care in hospitals. One physician in this study stated, “Patients love the idea of personalized care and doctors/physician assistants are thrilled that most of patient’s issues are solved.” On a human level, they know the PCF respects their time; they trust that the PCF will call them only for important things. However, that also means that the PCF will always advocate for the patient. Patient’s needs drive the PCF’s leadership role on the team. The PCF focuses the efforts of the whole patient care team on the patient and does so with expert clinical and loving care for all concerned.

### ***Communication***

Communication, too, emerged as a theme from all of the qualitative approaches. What characterized communication was not only that it was continual and in all directions, but also its quality. PCFs communicate in a respectful caring manner. As stated earlier, the PCF acts as the conductor, serving as the communication hub. All team members rely on the PCF knowing “the whole story” about a patient. PCFs keep apprised of all current tests and treatments, can help everyone know how to avoid duplication. In all communication among the team and family members, the PCF lets people know how important they are to the care the patient receives. Because the PCF operates from a loving, caring center all persons on the team, including patients and families, feel the positive energy that flows in communication from this center.

One PCF spoke about communication regarding a particularly difficult patient situation where the patient and family were extremely stressed, saying “...he had two or three strokes, they had infant twins, the wife was overwhelmed...I would go right away and get results, call the doctor...the doctor had to talk to the wife...someone had to give them information...” When speaking with the PCF, the interviewer could see the compassion emanating from her being. She cared about all the people on the team, and kept patient needs at the center. She highlighted that she was able to communicate with everyone—dietician, pharmacist, physicians, nurses, and nursing team—so that the patient and family received what they needed in a timely manner, in many cases within the hour. This story, with different particulars, was repeated over and over again through all of the qualitative data sources. Communication was key.

### ***Competence***

Only very competent caring nurses become PCFs. Expert practice as a staff nurse underpins the role. When interviewing candidates for the PCF role, the selection committee presents patient care situations to candidates as part of the process. Those selected for the role demonstrate high levels of caring and clinical competence. Because the PCF demonstrates a high degree of clinical expertise, physicians and other healthcare professionals develop trust in the role. A physician stated:

The PCF is the liaison between myself and the consultant or myself and the patient or they do the reviewing for me and let me know what is going on with this particular patient and they say he [the patient] is ready to go or they just need this procedure.

All the PCF’s competence comes to bear on a patient situation through the caring center, the soul of the role.

### ***Helping/Supporting***

This aspect of the role works for all team members, according to qualitative data sources. Physicians speak about the help they receive in their care of the patient. The PCF also helps the hospital to achieve aims for more efficient and caring patient care. When PCFs received the



charge to assist in compliance with Core Measures, a Medicare standard monitored by JCAHO, data indicated a clear rise in adherence to standards for the Core Measures examined. Most dramatic, however, regarding the helping/supporting theme was nurses who indicated they felt supported by the PCF. In the focus groups, nurses indicated the PCF steps in to assist with what needs to be done when a patient goes into crisis. The PCF can either free up the nurse to be with the patient in crisis by taking charge of that particular nurse's regular patient load or will stay with the patient in crisis while the nurse stays with the rest of his/her assigned patients. In a different example, a nurse stated, "When there is someone on board that is new, we try to help him or her out." The PCF acts as a mentor and role model for new nurses. In addition, helping/supporting characterized the PCF/patient relationship.

### ***Relationships (Comforting, Trusting, Friendship)***

Building relationships emanates from the center of the role as an expression of caring through caregiving, emotional connection, and love. It results in relationships that convey trust, comfort, and friendship. Friendship also relates to having a best friend at work, an item on the Gallup employee satisfaction survey. This seems to mean there is someone at work with whom people can confide for purposes of making work easier for them, someone they trust. Such relationships allow for free exchange of ideas, emotions, and caring energy; they are easy for all concerned. One staff member interviewee state, "I came from another floor...was there for a long time before this floor. Here I felt at home, like I was on my old floor." A patient expressed:

The first time you come in here you're nervous, you're frightened, you don't know what to expect and the PCF put me at ease. Since then I have been back on this floor 4 to 6 times...there was no fright...(after discharge) I came up to the floor and paid a visit, a social visit...I've done it all the time just to say hello, because they're friends. They're no longer nurses, they are friends who happen to be nurses."

"Friends" seems to be the best way for patients and others to describe the quality of the relationship. Another patient described it by saying about the PCF, "...very loving, very kind...I would say with love but I am not telling you the others were not the same. The entire staff was excellent...She was always, always very loving, affectionate. A friend, ...a friend."

### ***Continuity of Care***

One interviewee summed up the meaning of continuity:

I think it increases the continuity of care and also increases the patient's own comfort level of being in the hospital, always seeing that face. That face is like a constant thing that's there and you always know that they're there in that corner [where the 12-bed area is located].

Continuity resides in the flow through one person, the PCF, who knows everything about every aspect of that patient's care and who then acts to coordinate all team members' efforts in light of what the patient and family need. The care is seamless, smooth, and easy.

## **Discussion and Summary**

Both quantitative and qualitative results of this research study clearly supported the research purposes. Both continuity of care and caring increased as a result of the PCF role. In addition, patients felt more ready to go home when they were to be discharged. The PCFs knew all about what the patients in their care needed, not just from their intellect, but also with their whole being. They exemplified nursing practice from a caring center. A mutual feeling of love suffused

their practice and allowed them freedom to feel passionate about their role as nurses. They knew their patients at their most vulnerable. Information flowed back and forth among the PCF, patients, and their families and the care team. PCFs truly facilitated care for the patient and the care team. To facilitate means to make easy, smooth the progress of, help, aid, and assist. A PCF stated, "I make things easier for the patients and families." A physician said, "The PCFs communicate, they make my life easier as a physician." A social worker noted:

They are there to help the patients, help the nurses. They are available to talk to the doctors so the nurses can do what they need to do, take care of the patients...They help...They make a difference in the eyes of everyone.

And finally, from a patient:

Anytime I needed something, she was always there to ask her for what we needed. She was constantly there; she was supervising what was going on with the care. If we had a problem, if we had a need, or any other need we she was there.

The role, through its caring center, clearly helps to heal the wounds of the downsizing trend of the 90s for patients and families, patient care team, and hospital. All benefit.

Research still needs to be conducted on the economic implications of the model. The hospital and nursing administration know that the role depends on adequate nurse staffing. This means it costs more than traditional staffing. However, positive outcomes so strongly supported the worth of the model that the hospital and nurse administrators chose to implement the role in most of the hospital. A research team is now crafting an extension of this research study to address economic implications of the model.

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Table 1

*Response Rates for Each Data Source*

Data sources	N
Patient questionnaires from three nursing units	559
Staff questionnaires from three nursing units	123
Registered nurses	45
Clinical partners	28
Administrative partners	14
Physicians	18
Other professional teams: Social work, dietician, utilization review, physical therapy, respiratory therapy, administrative staff, and other groups	18
Individual in-depth interviews from one nursing unit	27
Focus groups from one nursing unit: 8 to 12 RNs from 7a-7p and 7p-7a	2 Groups

Table 2

*T-Tests for Independent Means — Had or Did Not Have a PCF by Carative Factors Subscales*

Carative factors subscales	Had PCF	N	Mean	t	p-value
Humanism/Faith-hope/Sensitivity	No	176	4.1841	-5.185	.000
	Yes	281	4.5515		
Helping/Trust	No	171	3.8561	-5.096	.000
	Yes	275	4.2594		
Expression of positive-negative feelings	No	164	3.6311	-5.126	.000
	Yes	261	4.2050		
Teaching/Learning	No	168	3.9270	-4.004	.000
	Yes	267	4.3232		
Supportive/Protective/Corrective environment	No	167	4.1462	-3.496	.000
	Yes	268	4.4123		
Human needs assistance	No	169	4.4153	-3.686	.000
	Yes	274	4.6636		
Existential/Phenomenological/Spiritual forces	No	165	3.8162	-3.889	.000
	Yes	258	4.2468		

Note: 1 = Never 5 = Always

Figure 1: PCF Role Themes from Qualitative Data Sources

