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Evaluation of Authentic Human Caring Professional Practices

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OBJECTIVE: The aim of this study was to present an instrument and comparative database designed to evaluate patients' perceptions of caring behaviors of caregivers.
BACKGROUND: Acute care leaders are under pressure to improve publicly reported patient satisfaction scores. Some nurse leaders have implemented professional practice environments based on human caring theory, whereas others have used scripting to standardize communication between staff and patients.
METHODS: The Watson Caritas Patient Score (WCPS) is collected quarterly from a random sample of patients who are admitted to acute care hospital units.
RESULTS: The WCPS was able to discriminate across unit types and hospitals. Items were related to publicly reported nursing communication scores.
CONCLUSIONS: Participation in research based on human caring theory has given nurse leaders the opportunity to evaluate effectiveness of professional practice environments. It may provide the opportunity to focus staff communication with patients more authentically and in a way that enriches the experience for both.

The purpose of this article is to report on a caring science research project, which measures patients'

experience of authentic professional human caring practices.[1] This caring science practice approach applies to caregivers toward each other as well as patients/families and communities.

Background

Scripting as an Intervention to Demonstrate Caring

As hospitals seek approaches to improve patient satisfaction, and address finances, many administrators resort to scripting as 1 way to solve nurse-patient communication and improve outcomes. Perhaps there is some benefit to scripting as a means to guide communication and interactions; however, inauthentic communication is detected immediately by patients.[2] Leadership wisdom dictates that administrators can have the greatest strategy to improve patient care, but "it is culture, which will eat strategy for lunch."[3] To be successful, communication and nurse-patient relations require "authentic presence" and ways of being, which are reflective, sensitive, and present to the patient/family situation in the moment—connecting human-to-human.[4] Personal self-reports from nurses in hospitals where scripting is used find the requirement intrusive, artificial, demoralizing, and insulting.[5] This is especially true for nurses committed to theory-guided, professional caring science practice. Caring Science hospitals and staff hold a sacred covenant with their patients. When nurses are most in touch with that covenant, they appreciate the need to form trusting relationships with patients/families and to be authentically present during interactions and even brief moments of communication.[6]

Attempts at scripting a caring moment[7] and any authentic interaction is an oxymoron. Such a structured approach, based on administrative attempts to improve outcomes, undermines the possibility for an authentic human-to-human connection.[2] Moreover, scripting goes against long-standing, educational teachings of

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therapeutic use of self," common to all nurses, embedded in the timeless, classic teachings of Peplau,[8] and, more recently, practices informed and guided by caring science theoretical values, philosophy, and ethics as a mature professional model.[4,9] Indeed, recent Institute of HeartMath research affirms that inauthentic communication is detected immediately, energetically, and intuitively and affects the larger field of communication. So, both philosophically, as well as empirically, scripting is not a solution to improved patient care and hospital outcomes.[10]

The maturing of nursing professional practice models, despite the dominant medical disease hospital system and conventional administrative attempts to scripting as a way forward, is revolutionary. Magnet® hospital's success in instituting a professional nursing model has had major impact on hospital staff, patients, and society alike.[11,12] However, even with these best practice hospital successes, and with the maturing of nursing as a distinct discipline and profession, the professional practices for improving patient care are still surrounded by an outdated scientific Western worldview. This worldview is confined to physical body care, medical-disease, acute sick-care hospital practices, compounded by external technical interventions. This approach to patient care and models of care delivery is based on latent and overt norms established by the institutional, industrial product-line, hospital culture of this so-called modern era.[7]

Evolution to Health

Global shifts are upon us in healthcare. These shifts are awakening toward philosophical value-guided health approaches toward whole-person/whole-system caring-healing health. The human consciousness shifts toward wellness are awakening to energetic models and possibilities of inner healing and emotional and mental health, oriented toward subjective, experiential indicators such as individual self-love, self-caring, self-knowledge, self-control, and self-healing health approaches, addressing individual and collective human suffering. This evolving view for humankind and population health returns us to the heart of our humanity and heart of nursing; it invites and requires practices for sustaining a healthy environment and human environment caring for our well-being.[4]

What is happening today, in this era in human history, demands an expanded, dramatically different, worldview, quantum shift. The quantum move is away from episodic sick care and from material medicine and external interventions and cure of body, at all cost—physically, mentally, economically, spiritually. New research models are needed to generate data that explore authentic human caring-healing health, in contrast to the physical-cure biomedical views of sick care.[13-15]

Methods

To shift the focus from objective, problem-oriented criteria and measures that address the status quo, this study, grounded in caring science, represents an expanded framework for healthcare and subjective outcomes, guided by authentic human-to-human caring and assessing core variables of patient experiences of caring. The study uses a descriptive design and is part of an ongoing national comparative database project. Participants submit quarterly responses from a random sample of patients who are hospitalized on adult acute care and rehabilitation units. Further description of the data collection procedure is below. The results reported here are from the 2nd quarter of 2014.

Sample and Setting

The sample consists of 1010 patient responses from 48 units in 8 hospitals located throughout the United States. All hospitals are either affiliates or research partners of Watson Caring Science Institute.[16] Quarterly hospital coordinators from each of the 8 hospitals collect a random sample of patient surveys from each of the 48 units and submit them to the database. Because the unit of comparison is patient care units, all individual patient responses are aggregated to the patient care unit. Patient care units in the sample represent 10 different unit types, which are illustrated in the Figure, Supplemental Digital Content 1, http://links.lww.com/JONA/A430. The most frequent unit type is medical-surgical (n = 15), and least frequent is moderate acuity adult (n = 1).

Patients reported a mean age of 58.7 (SD, 16.9) years, had been on the hospital unit for 5.8 (SD, 7.3) days, and had 3.1 (SD, 2.3) health problems and a pain score of 3.1 on a scale of 1 to 10, 1 indicating no pain and the worst possible pain (score, 10). In addition, 54% of the sample was female (n = 537), with an equal proportion (40% each) reporting bad and very bad health. Forty-five percent (n = 437) came to the hospital with an emergency condition, 55% (n = 554) were white, and 43% (n = 437) were on bed rest, whereas 37% (n = 370) were able to sit on a chair at the bedside.

Measures

The measurement assessment is Watson Caritas Patient Score (WCPS) (Figure 1),[17] capturing the patient's experience of caring. The 5 items of the WCPS emerged from the Watson theory of 10 Caritas Processes (Figure 2) as universals of caring phenomenon and foundational indicators of human caring.[4,18] Response options for each item range from 1 (never) to 7 (always). The items empirically assess the patient's subjective experience of receiving caring; the items refer to such

Watson Caring
Science Institute

Watson Caritas Patient Score©

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

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

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

Thank you for completing our questionnaire!

Figure 1. Watson Caritas Patient Score. Used with permission.

TEN CARITAS PROCESSES™ – Jean Watson Theory of Human Caring (4)

1. Humanistic-Altruistic Values – Practice of Loving Kindness and Equanimity with self/other;
2. Being Authentically Present -Enabling Faith-Hope;
3. Being Sensitive to self/others by cultivating own spiritual practices – beyond ego-to transpersonal presence;
4. Developing and Sustaining loving, trusting-caring relationships;
5. Allowing for expression of positive and negative feelings – authentically listening to another person's story;
6. Creatively problem-solving – 'solution-seeking' through caring process; full use of self – use of all ways of knowing;
7. Engaging in transpersonal teaching-learning within context of caring relationship; staying within other's frame of reference – shift toward coaching;
8. Creating a healing environment at all levels; subtle environment for energetic authentic caring presence;
9. Reverentially assisting with basic needs as sacred acts – touching mindbodyspirit of other; sustaining human dignity;
10. Opening to spiritual, mystery, unknowns – allowing for miracles.

Figure 2. Ten Caritas Processes, Watson's Theory of Human Caring. Used with permission.[4]

indicators as loving kindness, trust, dignity, healing environment, and honoring of beliefs and values (Table 1). The scale demonstrates satisfactory internal consistency reliability, Cronbach's α = .90.[19] Construct validity has been evaluated using exploratory factor analysis with principal components using varimax rotation, which resulted in a single factor explaining 76% of the variance. Table 1 presents factor loadings by item, which ranged from 0.766 to 0.906. The 2nd measure used in the study is a 10-question demographic survey, which asks standard questions such as age, number of health issues, reason for hospitalization, ethnicity, mobility level, educational level, and current pain level.

Procedure

The project received approval from The University of Arizona human subjects review board as well as at each hospital. Following human subjects approval, a hospital coordinator from each site received training regarding all project procedures. Each site selected and trained data collectors. Project requirements specified that data collectors not be employed on the unit where they collected data to reduce possibilities of biasing patient responses.

Patient surveys were distributed to a random sample of patients who had been hospitalized on the current unit for a minimum of 24 hours, were 18 years or older, and were cognitively able to complete a survey in English. Surveys were distributed throughout the quarter, and all but 1 site, which collected data using an iPad, used paper surveys.

All site coordinators, with the exception of the 1 using the iPad, entered data through a secure online portal. Individual hospital and comparison reports are accessed through a different page on the same online portal.

Data Analysis

All data analyses were done using Statistical Package for the Social Sciences (Armonk, New York). Individual-level data were aggregated to the unit level and evaluated for group-level validity using the criteria recommended by Shortell and colleagues.[20] Descriptive statistics were used to evaluate differences across unit types and hospitals. Nonparametric correlations (Spearman ρ) were performed to examine relationships among caring items and unit-level quality indicators.

Results

All individual items and the scale score met Shortell and colleagues'[20] criteria ($F > 1.4$, $P < .05$) for aggregation of individual items to reflect a group (patient care unit) score. Mean scores for each of the 5 items and the total scale ranged from 5.7 to 7. There were statistically significant differences in 3 of the 5 items and the total scale score among the 8 hospitals in the sample. Table 2 provides the breakdown of hospital scale means and SDs. As can be seen from Table 2, 2 of the 8 hospitals exhibited statistically significant differences in the WCPS.

Each of the 5 items and the WCPS (Figure 1) were correlated with Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores[21]

Table 1. *Factor Loading of WCPS Items*

Item	Loading
Create a caring environment that helps me to heal	0.906
Deliver my care with loving kindness	0.904
Have helping and trusting relationships with me	0.899
Meet my basic human needs with dignity	0.868
Value my personal beliefs and faith, allowing for hope	0.766

Table 2. WCPS by Hospital				
Hospital	Mean	SD	F	P
A	6.69	0.13	3.042	.012
B	6.37[a]	0.24		
C	6.70[a]	0.03		
D	6.54	0.17		
E	6.49	0.25		
F	6.48	0		
G	6.65	0.19		
H	6.41	0.21		

[a]$P < .05$.

for the participating patient care units. The HCAHPS items selected for the analysis were communication with nursing, responsiveness of hospital staff, pain control, communication about medicines, quietness of hospital environment, cleanliness of physical environment, discharge information, overall hospital rating, and recommending the hospital to family and friends. The items were selected because they were believed to be most sensitive to nursing care and the practice environment.[22] Two of the HCAHPS items, communication with nursing and responsiveness of hospital staff, correlated with 3 of the WCPS items. Communication with nursing correlated with 3 items, meet my basic needs with dignity (Spearman $\rho = 0.33$, $P < .05$), helping and trusting relationships (Spearman $\rho = 0.36$, $P < .05$), and create a caring environment that helps me to heal (Spearman $\rho = 0.43$, $P < .01$). Responsiveness of hospital staff correlated with 1 item, helping and trusting relationships with me (Spearman $\rho = 0.33$, $P < .05$).

Discussion

The WCPS items and scale were able to discriminate across unit types and hospitals. The scale demonstrates satisfactory internal consistency, reliability, and validity. Its use, whether for research as in this case or in practice for understanding caring from the patient's perspective, invites a very different conversation from other patient experience measures. Anecdotally, hospital site coordinators have told the authors they have used the instrument on units other than those in the study as a means for engaging patients in conversations, because both staff and patients appreciate the meaningful discourse the questions engender.

Three of the WCPS items correlated with 2 HCAHPS items, communication with nursing and responsiveness of hospital staff. This finding is consistent with the findings of a systematic review examining the effects of caring and patient satisfaction of hospitalized adult patients[23] and the findings of Esmaeili et al,[24] who found that cardiac critical care patients described behaviors associated with patient-centered care as carefully listening to them by the nursing staff. In addition, relationship between caring behaviors of the staff and satisfaction with nursing supports the findings of Tonges and colleagues,[12] who found nurse satisfaction scores increased with the implementation of a professional practice model based on caring.

Limitations

This study is part of a larger ongoing comparative research project, the participants of which are all Watson Caring Science Affiliate hospitals or research partners. As a result, the caring scores are higher than what might be expected across all hospitals, which may have blunted the magnitude of correlations between the caring items and the nurse-sensitive quality indicators. When correlation coefficients are calculated using scores from a restricted range (as in this case, higher caring scores than might be seen across all hospitals), the strength of the correlation may appear that there is no or a weak relationship between 2 variables.[25] In addition, although the sample was random, it may not fully represent all patients on the participating patient care units because of the small number of patients sampled within the quarter of analysis.

Implications for Management

In the last few years, there has been a shift toward measurement of patient subjective experiences versus objective criteria alone. The WCPS provides some insight into a patient's subjective experience of caring staff behaviors. Despite the move to measurement of more subjective experiences, reality still remains that unless systems have indicators of caring and patient experiences it is not reliable or possible to have data relating caring process of nursing to outcomes. The WCPS has given nurse leaders some evidence of the effectiveness of their professional practice model through the patient's eyes. This direction for assessing and validating caring provides new forms of evidence consistent with transformation within systems for whole-person/whole-system shifts related to healthcare reform and evolved consciousness of the public beyond medical technical care alone.

Conclusion

The WCPS is a valid and reliable tool that may be used by nurse leaders who have built professional practice environments based on human caring theory to evaluate their effectiveness. The tool has successfully been used to compare caring staff behaviors across hospitals and unit types and has

shown relationships to patient assessment of nursing communication and staff responsiveness. It may provide an alternative measure of patient subjective feelings of the care they have received.

References

1. Watson Caring Science Institute. In: *International Watson Caritas Comparative Database.* 2015. http://watsoncaringscience.org/international-watson-caritas-comparative-database/. Accessed July 1, 2015.
2. Kay Hogan B. Caring as a scripted discourse versus caring as an expression of an authentic relationship between self and other. *Issues Ment Health Nurs.* 2013;34(5):375-379.
3. Coffman CW, Sorensen K. *Culture Eats Strategy for Lunch: The Secret of Extraordinary Results Igniting the Passion From Within.* Denver, CO: Liang Addison Press; 2013.
4. Watson J. *Nursing: The Philosophy and Science of Caring.* Rev. Ed. Boulder, CO: University Press of Colorado; 2008.
5. Sweeney C. "We love scripting" …said no nurse ever. *Ariz Nurse.* 2014;67(4):3.
6. Clarke PN, Watson J, Brewer BB. From theory to practice: caring science according to Watson and Brewer. *Nurs Sci Q.* 2009;22(4):339-345.
7. Sitzman K, Watson J. *Caring Science, Mindful Practice: Implementing Watson's Human Caring Theory.* xvi, 152 pages. New York: Springer Publishing Company.
8. Peplau HE. *Interpersonal Relations in Nursing, A Conceptual Frame of Reference for Psychodynamic Nursing. Modern Nursing Series.* New York: Putnam; 1952.
9. Watson J. *Nursing. The Philosophy and Science of Caring.* Boulder, CO: University Press of Colorado; 1979.
10. Institute of HeartMath. *Welcome to HeartMath Research.* 2015. http://www.heartmath.org/research/research-home/research-center-home.html. Accessed February 3, 2015.
11. Stimpfel AW, Rosen JE, McHugh MD. Understanding the role of the professional practice environment on quality of care in Magnet(R) and non-Magnet hospitals. *J Nurs Adm.* 2014; 44(1):10-16.
12. Tonges M, McCann M, Strickler J. Translating caring theory across the continuum from inpatient to ambulatory care. *J Nurs Adm.* 2014;44(6):326-332.
13. Watson J. *Postmodern Nursing and Beyond.* Boulder, CO: Watson Caring Science Institute; 2010.
14. Watson J. Integrative nursing caring science, human caring, and peace. In: Kreitzer MJ, Koithan M, eds. *Integrative Nursing.* New York: Oxford University Press; 2014;101-108.
15. Watson J. Social/moral justice from a caring science cosmology. In: Kagan PN, Smith MC, Chinn PL, eds. *Philosophies and Practices of Emancipatory Nursing: Social Justice As Praxis.* Routledge: New York; 2014;64-70.
16. Watson Caring Science Institute. Inter/National WCSI Affiliates. 2015. http://watsoncaringscience.org/international-wcsi-affiliate/. Accessed January 9, 2015.
17. Brewer BB, Watson J. Watson Caring Science Institute. Dare to care: national comparative database of caring professional practice indicators through the patient's eyes. Poster presented at the International Nursing Administration Research Conference; November 2013; Baltimore, MD.
18. Watson J, Brewer BB. Guest Editorial. Caring science research: criteria, evidence and measurement. *J Nurs Adm.* 2015;45(5).
19. Watson J, Brewer BB, D'Alfonso J. Caritas: a theory guided scale to measure human caring. Poster presented at the 2010 State of the Science Congress on Nursing Research; September 2010; Washington, DC.
20. Shortell SM, Rousseau DM, Gillies RR, Devers KJ, Simons TL. Organizational assessment in intensive care units (ICUs): construct development, reliability, and validity of the ICU nurse-physician questionnaire. *Med Care.* 1991;29(8):709-726.
21. HCAHPS. http://www.hcahpsonline.org/home.aspx. Accessed June 30, 2015.
22. American Nurses Association. *Nursing Care Report Card for Acute Care.* Washington, DC: American Nurses Publishing; 1995.
23. Wolf ZR. Systematic review of effect of a caring protocol provided by nursing staff on patient satisfaction of adult hospitalized patients. *Int J Human Caring.* 2012;16(4):58-70.
24. Esmaeili M, Cheraghi MA, Salsali M. Cardiac patients' perception of patient-centred care: a qualitative study. In: *Nurs Crit Care,* 2014.
25. Kiess HO, Green BA (Eds). *Statistical Concepts for the Behavioral Sciences.* 4th ed. Boston, MA: Allyn & Bacon; 2010.