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Assessment of Intensive Care Family Satisfaction

Jami Burnette

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Assessment of Intensive Care Unit Family Satisfaction

by

Jami Burnette

A capstone project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
Doctorate of Nursing Practice

Boiling Springs, NC

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SECTION I

Problem Recognition

There continues to be an unknown factor in knowing true patient and family satisfaction within the intensive care unit (ICU) setting. Current literature reveals surveys used to measure patient satisfaction do not pertain to the ICU setting. Patients often do not remember the ICU stay due to critical illness and are unable to actively participate with care. Families act as surrogates, are included in patient care, and collaborate with nursing and medical teams to help make care decisions. Families are integral in the patient care process and are vital members of the health care team. Even though families are included with patient care, there is currently no valid tool being used to survey patients and families in order to capture satisfaction and make necessary patient care improvements.

Problem Identification

The project site is an acute-care Level I Trauma Center located within the Upstate of South Carolina. Services include emergency medicine, medical, surgical, women's and children's, a heart center, critical care, outpatient testing, and a number of specialty accredited programs. The surgical/trauma/neuro specialty, adult ICU is the focus unit of the initiation of a family satisfaction survey project.

The specialty ICU nursing team continues to voice frustrations of patient satisfaction data not specific to critical care stay experience. The current survey tools mandated and used to capture patient satisfaction are not inclusive to the ICU patient stay experience and only capture approximately 10% of the total ICU patient volume, which makes it difficult for the nursing team to make quality improvement in care. Finding a

potentially sustainable way to capture and measure satisfaction within the ICU setting supports the healthcare team's mission to continue the never-ending journey of improving overall care, family inclusion with care, decision making, and end-of-life measure.

Project Goal

The critical care nursing team currently has no quantifiable or sustainable tool that properly captures ICU family satisfaction. The purpose of this project was to implement a potentially sustainable way to capture and measure intensive care unit family satisfaction to use as a quality metric to evaluate the perceived quality of patient care in the ICU setting and integrate into ICU quality improvement planning. Initiation of an intensive care patient and family satisfaction survey project contains three phases. Phase one includes using a paper questionnaire to survey families on day three of the ICU stay and will be completed by March 2020. Phase two will include a poster with a scannable quick-response (QR) code that can be scanned from a personal device and linked to an electronic version of the family satisfaction survey. Phase three includes the adoption of the family satisfaction questionnaire by all adult ICUs at the project facility. Phase two and three will be completed after May 2020.

HCAHPS

The critical care nursing team receives Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) inpatient unit scores. HCAHPS is a way the Centers for Medicare and Medicaid (CMS) measures and reports patient satisfaction but only evaluates the patient experience based on the entire inpatient stay (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment->

Instruments/HospitalQualityInits/HospitalHCAHPS). The HCAHPS survey is mailed to the patient weeks to months following the hospital stay and produces an inpatient summary of the patient's recalled experience, which is used to determine reimbursement. The ICU experience gets lost within the whole patient stay due to the patient not remembering their ICU care due to severity of illness, the family not being present, or due to sedation/medication the patient was receiving. Although vital information regarding the ICU experience is not captured within HCAHPS, it is recognized to be the only national public report of patient satisfaction, and there is no intent within this project of disproving that fact.

Press Ganey

The Press Ganey (survey vendor) supplemental questions to the HCAHPS survey provides the analysis of four questions asked regarding the ICU stay: (1) friendliness/courtesy of ICU nurses, (2) ICU nurse help understand treatment/therapies/condition, (3) attention special/personal need ICU, and (4) skill of ICU/CCU nurses. Between January 1, 2019 and March 31, 2019, only 79 respondents with an ICU stay completed the HCAHPS survey out of a potential ICU census of 810 from the project facility's four adult intensive care units. This only represents about 10% of potential surveys and 12% of total hospital-wide patient feedback that was captured out of all 633 respondents. The HCAHPS inpatient report and Press Ganey is completed by the patient after discharge and do not provide enough information or feedback to support adequate ICU quality improvement processes that have the potential to improve ICU satisfaction.

Family Satisfaction as a Quality Metric

ICU patient-centered care involves the family, which is why the Society of Critical Care Medicine (SCCM) recognizes the family-centered concept and associated practice guidelines (Davidson et al., 2017). Family members act as surrogates and participate with care and health team decisions. Many patients do not remember the ICU stay and cannot recall the care received since most are unable to participate with care decisions (Heyland et al., 2018). Families must be included in satisfaction surveys in order to improve the quality of care in the ICU and improve the inpatient reports that determine reimbursement. Quality indicators such as patient satisfaction, length of stay, Catheter Associated Urinary Tract Infection (CAUTI), Central Line Associated Bloodstream Infection (CLABSI), hospital acquired infections, and hospital acquired wounds are all key indicators of ICU quality. Family satisfaction must be a key indicator of quality for ICU since the patient's recall is poor. Finding a reliable and sustainable way to measure family satisfaction in the ICU is necessary to improve satisfaction and quality of care, which are both vital for hospital reimbursement.

FS-ICU 24R

The FS-ICU 24 contains three essential care domains: patient satisfaction, decision making, and quality end-of-life care (Family Satisfaction with the ICU Survey, 2019). Literature reveals that the FS-ICU 24R is a valid tool widely studied and used in ICU settings throughout the United States to gather valuable information to improve quality care (Clark et al., 2016). The FS-ICU 24R measures satisfaction with care (14 items) and satisfaction with decision-making (10 items). In addition, three free-text questions ask how to make the ICU care provided better, what things the staff did well,

and for any comments or suggestions that may be helpful. The FS-ICU 24R is completed by using a 5-point Likert scale: 1 = excellent, 2 = very good, 3 = good, 4 = fair, 5 = poor; a score of 6 indicates a response of not applicable (Family Satisfaction with the ICU Survey, 2019). The FS-ICU 24R paper questionnaire will be given to families on day three of the ICU stay.

Practice Change Recommendations

Clinical practice guideline (CPG) recommendations for implementing a valid tool for family satisfaction in the ICU begins with improving communication between the family and physician team (Davidson et al., 2017). Improved communication builds family satisfaction trust and reduced anxiety (Davidson et al., 2017). Scheduled ICU family meetings that occur within 72 hours of admission between the health team and family improves communication, allows the team to discuss the role of the family within the ICU, allows the family to review the medical record, and ask questions (Awdish et al., 2017). Another CPG recommendation to improve family satisfaction is to include the family in interdisciplinary rounding (Davidson et al., 2017). There is also a correlation between decreased hospital-acquired conditions and reduced falls by including family in multidisciplinary rounds (Mitchell, 2014). Quality care, safety, and family engagement are necessary to achieve family satisfaction (Mitchell, 2014).

Gap Analysis

Table 1 provides the selected guideline recommendations in comparison to current practice. Medical staff rounding variations exist between the medical and surgical physician intensive care teams. While the nursing team is proactive with including family in patient care, the medical team, due to time constraints or schedule,

may or may not involve the family in rounding. Due to these inconsistencies, families become frustrated as do the nursing team. Often, the charge nurses ensure that families do not leave the patient room until the physician team rounds.

Table 1

Gap Analysis-CPG Guideline Recommendations

Selected Guideline Recommendations	Existing Policy? Yes/No	Policy being followed? Yes/No
1. Medical Staff Rounding on Families in the ICU	No specific guideline or policy in place.	N/A
2. Flexed Visiting Hours	Yes-Unit Guidelines in place.	No- Inconsistent practice

Note. CPG guideline-based recommendations compared to the current practice of the focus unit.

Scope of the Problem and Readiness for Change

The project's scope aims to initiate a sustainable way to measure and validate family satisfaction in the ICU to make improvements in team communication, family decision-making, atmosphere, and overall patient care in a specialty ICU setting. Both the mission and vision of the health organization parallel the purpose of this project's clinical practice problem and are in line with project goals. The project facility is focused on patient, family, and associate satisfaction and takes great pride in ensuring quality care is available for the surrounding communities.

PICOT Statement

How will the assessment of an ICU family satisfaction survey improve the overall ICU satisfaction, family satisfaction with patient care, and satisfaction with family decision-making in an adult specialty intensive care over a one-month time frame?

Target Population

The focus setting was an adult specialty intensive care unit in a Level I trauma center in the Upstate of South Carolina that provides critical care treatment to neuro-surgical-trauma patients. The unit has 22 beds, one nurse leader, one assistant nurse leader, 57 registered nurses, five unit ambassadors and four patient care technicians. The project chair is the current nurse leader of the practice problems setting. Barriers with the practice setting include patients that have no family members present, family that does not participate with care, and patients who are not coherent enough to participate with care. The unit has flexed visiting and each room has an integrated family area. The focus unit considers family as vital members of the health team.

SECTION II

Needs Assessment

A needs assessment is performed to evaluate the organization's readiness for change (Zaccagnini & White, 2017). The critical care nursing team currently relies on HCAHPS for satisfaction improvement related plans. HCAHPS is nationally recognized as the only patient satisfaction tool that is linked to hospital reimbursement but does not isolate the ICU stay. HCAHPS will continue to be the primary reporting tool but there is an evidence-based gap for ICU reporting. The family is also the customer and participates with treatment planning. The valid FS-ICU 24R survey is completed by the family, helps the ICU team know what is going well, and helps to identify opportunities for improvement. Knowing the customer and recognizing that the family's perception of the ICU experience is important to capture for ICU quality improvement purposes (Mazurenko et al., 2016).

Practice Change Implementation Team

One of the responsibilities of a nurse leader is to drive change within the current clinical setting and nursing profession (Zaccagnini & White, 2017). Both internal and external stakeholders have important team roles and contribute towards the success of the team. The ICU nursing leaders recognize the importance of change and value it. Implementing a successful project that makes a positive impact on the patient, family, the health team including ancillary departments and organization is the overall goal.

Team Members

The project leader gathers evidence for the interdisciplinary group to support the need for the tool. The project leader also selects the team, provides guidance and

structure, ensures understanding of the project's purpose and goal, keeps the team on track, ensures team member roles and responsibilities, promotes a safe environment, and holds team members accountable (Ulrich & Crider, 2017). The plan is to maintain a small group of full-time members with a few additional ad hoc members as the project progresses. Implementing a family satisfaction tool for use in the intensive care area meets the qualifications of a quality improvement team based on who will be affected by the result, which is the patient, family, nursing, leadership, quality, and the organization (Ulrich & Crider, 2017).

Internal Stakeholders

Team members and internal stakeholders selected are nursing representatives for information exchange and buy in. Since the project includes three phases of implementation, phase one will only be completed before May 2020. Phase one involves the primary investigator and nursing leader of the project ICU to distribute the paper family satisfaction questionnaires to all families who have been in the ICU for at least three days. Phase two and three both involve a scannable way to access an electronic version of the tool and project sustainability. Phase two and three will not be completed until after May 2020. The project investigator envisions collaboration from many team members as this project moves forward. Nursing, guest services, waiting room attendant, quality services, adult ICU unit leaders, and the medical team are all internal stakeholders that will be active members of the family satisfaction project.

External Stakeholders

Key external stakeholders are the ICU family members and those affected by having a loved one in the ICU. Other stakeholders include ancillary departments that

work within the ICU environment, which include housekeeping, respiratory care, case management, pharmacy, long-term care placement teams, unit ambassadors, and dietary. All the mentioned services interact with the patients, impact care, and satisfaction. It is understood that satisfaction perceptions are not only from nursing but from a collaborative effort by all who interact with the patient while in the ICU.

Barriers/Facilitators/Strategies: SWOT Analysis

A SWOT analysis is performed to identify strengths, weaknesses, opportunities, and threats that impact project success (Harris et al., 2016). A SWOT analysis is often performed for DNP projects and helps to proactively guide the project (Zaccagnini & White, 2017). The SWOT approach is used in the early stages of project planning and development (Ramsay, 2015).

Strengths

The unit has flexed visiting with family area in each patient room. The setting and building are new with spacious rooms that contain patient lifts, antimicrobial surfaces, and new equipment. The waiting area outside of the unit has a fulltime associate that assist families. The family waiting room design both in and outside the patient area facilitates optimal family satisfaction. Project investigator is the project unit leader. The designed poster with the scannable QR code provides project sustainability that will be introduced in phase two and three.

Weaknesses

The specialty ICU has a high number of falls, device related injuries, and unplanned extubations. HCAHPS scores for current inpatient performance reveal low physician communication, medication education, and transitioning of care score. There

are many registered nurses currently in advanced-degree programs, many new-graduate RNs, many planned maternity leaves, and a few who are wanting to do travel nursing. The project investigator is the unit leader.

Opportunities

Patient falls, device related injuries, and unplanned extubations may potentially impact project survey scores but not project success. Nursing leadership is currently performing daily huddles and rounding with the direct care team in hopes to improve both falls and unplanned extubations. Other opportunities mirror weaknesses.

Threats

Potential threats include no family or disengaged family. There is also the threat of family not wanting to participate in a survey. Organizational leadership may not want the guests surveyed while in the hospital for fear of not accepting a phone call when discharged to complete the current satisfaction survey that is mandated. The trial could impact family perception of being over surveyed and present as a barrier to the project's success.

Fiscal and Physical Resources

The clinical practice project will have minimal cost to the organization. Use of the survey is free. Printing will come from the copy center and costs are covered under the unit's operating budget. It will cost approximately 300 dollars for 300 copies of the survey. Plans are to distribute the survey on day three of the ICU stay. There will be no cost to distribute. There are no other costs associated with the FS-ICU 24R project. Cost-benefit is difficult to measure since the desired outcome is improved satisfaction and patient care.

Desired and Expected Outcomes

The project's goal was to establish a quantitative survey method and sustainable way to measure patient and family satisfaction in the ICU setting. Improved patient and family satisfaction and a higher number of returned surveys are the desired outcomes. It is difficult to determine current measurable family outcomes since the HCAHPS satisfaction survey has either a positive or negative result. Press Ganey is also only able to capture less than 10% of the total number of all ICU patients. The FS-ICU 24R will help to quantify overall patient care satisfaction and family decision making while in the ICU. There may also be potential qualitative measurements of family satisfaction observed by the nursing team. Weight gain, eating regular meals, low levels of anxiety, and normal sleep patterns are observational signs of family satisfaction (Eustace et al., 2015).

Outcome Measurement

Patient- and family-centered care (PFCC) is vital to maintaining family satisfaction while in the ICU (Wolf, 2017). Most common outcome measurement of PFCC is patient satisfaction. The HCAHPS is mandated by CMS and surveys adult patients to determine patient satisfaction (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html>). HCAHPS provides a summary of the entire inpatient stay including intensive care and provides one overall score. Some organizations study quality outcomes to determine quantitative feedback from PFCC, which are readmission rates and length of stay (Eustace et al., 2015). Another empirical method is associate engagement. Hospital culture, which includes expected associate behavioral standards, is linked to positive

patient experiences and patient satisfaction (Wolf, 2017). The desired outcomes are to interpret the assessment of patient/family ICU satisfaction determined by the FS-ICU 24R questionnaire, to use the FS-ICU 24R tool information as a quality metric to improve the overall care provided to the patient in the project ICU, and to provide a sustainable way to capture ICU family satisfaction for the purpose of quality improvement.

SECTION III

Goals, Objectives, and Mission Statement

Project Goals

Project goals are prioritized according to the project institution's mission, patient safety, and nursing process satisfaction (Zaccagnini & White, 2017). The purpose and goal of the assessment of ICU family satisfaction survey project is to implement an evidence-based satisfaction tool, FS-ICU 24R, to better capture family feedback and provide measurable outcomes of patient care that was delivered in the project critical care unit. The patient's spouse or closest living relative will complete the satisfaction survey on day three of the ICU stay. Survey results will provide patient care specifics of current performance as well as how to improve the care provided to future patients in three categories: overall satisfaction with care, how the patient and family were treated, and satisfaction with decision making. The results will be interpreted and used to improve the quality of care provided in the project critical care setting. The long-term goal of the family satisfaction survey project is to be implemented in all four adult critical care units. Figure 1 shows the process/outcomes objectives.

Figure 1*Process/Outcome Objectives*

<u>Goals</u>	<u>Process/Outcome Objectives</u>
Understand the importance of patient/family satisfaction.	<ul style="list-style-type: none"> • The critical care health care team will be educated on the importance of patient and family satisfaction and the impact to patient care and outcomes. • The team will be educated within three months of phase one completion and before phase two and three implementation. • Education/Inservice to include a print-out copy of the FS-ICU 24R survey and related references to survey validity.
Successful survey implementation.	<ul style="list-style-type: none"> • Phase One- use of paper surveys distributed to ICU families on day three of the ICU stay. • Phase two and three- use of a poster that contains a scannable QR-code for easy access to the electronic survey tool. • Ensure there is no impact to critical care nursing workflow or interference with the patient satisfaction HCAHPS or Press Ganey survey. • Project site patient experience officer to approve survey implementation two months before process go-live.
Understand the importance of survey follow-up, action planning, and ongoing improvement (performance improvement).	<ul style="list-style-type: none"> • Phase one- project investigator distributes the survey, collects the survey, and enters all data. • For phase two and three preparation the project investigator will educate the nursing leaders of the purpose of the project and the importance of project sustainability as it impacts patient care quality. • The project investigator will guide other leaders in the

	<p>associated action steps based on the survey results. Action plans will be updated every month and will be based on prior months survey results.</p> <ul style="list-style-type: none"> • Critical Care performance improvement related to patient and family satisfaction will be posted on the unit quality improvement bulletin boards for transparency. Critical care nursing leaders to be educated on the patient and family satisfaction performance improvement plan one month before process following completion of phase one.
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Mission Statement

The mission of the project facility states that its goal is to provide excellence in health. The mission of this project is to improve the nursing care provided to the ICU patient by implementing an evidenced-based family satisfaction survey that encourages family feedback on the care of the patient while in the critical care unit. Feedback regarding nursing care includes three dimensions, which are satisfaction with overall nursing care, how the patient and family is treated, and family involvement with treatment decisions while in the critical care unit. The family satisfaction survey project provides a measurable way for nursing and the medical team to achieve and maintain the highest level of intensive care unit (ICU) nursing care.

SECTION IV

Theoretical Underpinnings

Nursing Theory

Because most patients are not aware of the nursing care within the ICU, the nurse communicates with, cares for, and meets the needs of the family. Nurse to family partnerships and relationships begin to develop. Family members are critical in the process of patient recovery during and after a hospital stay. The nurse must be available to those participating with the patient's care and prepared to pay special attention to the family's own needs and reactions during the ICU experience. Awareness of nursing theory enables the nurse to apply key concepts to move beyond the care of the patient and include the family as a part of the care planning.

Jean Watson's Theory of Human Caring

Watson (2019) describes the Theory of Human Caring as a caring science perspective that is grounded by relationships and connectedness. Caring relationships are authentic, intentional, and sometimes spiritual. The caring model is often considered the foundational framework of the nursing profession (Watson, 2019). According to Watson (2019), caring is transpersonal and moves beyond the ego-self and reaches deeper connections to the spirit to detect the other person's condition of being. Caring is also inclusive to self, others, and patients and families (Watson, 2019). Human caring is about understanding the patient and family on a deeper level and respecting life experiences/cultures to be able to promote healing through a difficult situation (Watson, 2019). The Human Caring Theory encourages the nurse to make a difference on a deeper level and invite families into the patient-care journey. Watson (2019) describes the 10

carative factors or Caritas Processes (Figure 2) that are used by many nursing professionals as guidelines for putting love/heart-centered practice into action.

Figure 2

Jean Watson's 10 Caritas Processes'. Used as a guide to practice the loving, heart-centered approach to patient care

1. Practicing loving-kindness and equanimity within context of caring consciousness.
2. Being authentically present and enabling, and sustaining the deep belief system and subjective life world of self and one-being cared for.
3. Cultivating one's own spiritual practices and transpersonal self, going beyond ego self.
4. Developing and sustaining a helping-trusting, authentic caring relationship.
5. Being present to, and supportive of the expression of positive and negative feelings.
6. Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices.
7. Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference.
8. Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
9. Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care.
10. Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared for; "allowing and being open to miracles."

Note: Adapted from Watson, J. (2019). Caring Science Theory. <https://www.watsoncaringscience.org/jean-bio/caring-science-theory/>.

Applying Theory to Assessing ICU Satisfaction

Watson's Human Caring Theory is necessary to guide the ICU nurse to patient and family interpersonal relationships. ICU patients are acutely ill, and many are fighting for life, which requires the bedside nurse to remain focused in order to carry out nursing skills quickly. Because of this, the nurse may be viewed as task oriented. Timing of care and treatments is vital to maintain patient stability, and the family often perceives the nurse's actions as robotic unless the nurse understands how to incorporate the family into the patient's care. Watson's Human Caring Theory is the foundation of the nursing and

enriches the relationship between the nurse, patient, and family. Caring relationships help to promote positive patient outcomes (Wei & Watson, 2019). Promotion of the quality of patient care requires collaboration between the health care team and the patient's family and validates the core values of Watson's theory (Wei & Watson, 2019).

Incorporating Theory into DNP Project

Literature supports and validates the importance of family presence in the ICU. Even though previous ICU family research was conducted in pediatric ICU's the concepts have shifted over the past decade into the adult ICUs. Partnering with patients and families has proven to improve the quality of patient care and lowering costs by reducing ICU days, complications, and ICU readmissions (Heyland et al., 2018). Heyland et al. (2018) states that partnering with families helps patients feel more secure and increases patient and family satisfaction. How best to apply family partnering strategies remains unknown (Heyland et al., 2018). The basic concept of *caring* must be at the center of patient and family care and remain the core of the nursing process to achieve family satisfaction in the ICU setting (Heyland et al., 2018).

Caring Behaviors

Nursing theories are the core of nursing and provide a structured approach to nursing care. There are still gaps between theory and nursing practice (Wei & Watson, 2019). Caring behaviors are defined based on patient and family perception as attentive listening, comforting, honesty, patience, responsibility, providing information, touch, sensitivity, and respect (Calong Calong & Soriano, 2018). In high-stress environments like the ICU where the nurse's feelings are perceived as hidden within critical patient-

care tasks, the nurse must be taught how to recognize and reinforce caring behavior and use the skills learned to provide a family-centered approach to care (Weyant et al., 2017).

Caring and ICU Family Satisfaction

Understanding the link between the theoretical foundation of Watson's Human Caring Theory is vital for the nursing team to understand the importance of using a valid tool to assess ICU family satisfaction. The FS-ICU 24R will provide a baseline for the team to know where to begin to have a better impact on the patient care provided in the ICU environment. Assessment of current state of ICU family satisfaction allows the team an initial summary of how families perceive the nursing care provided.

SECTION V

Work Planning

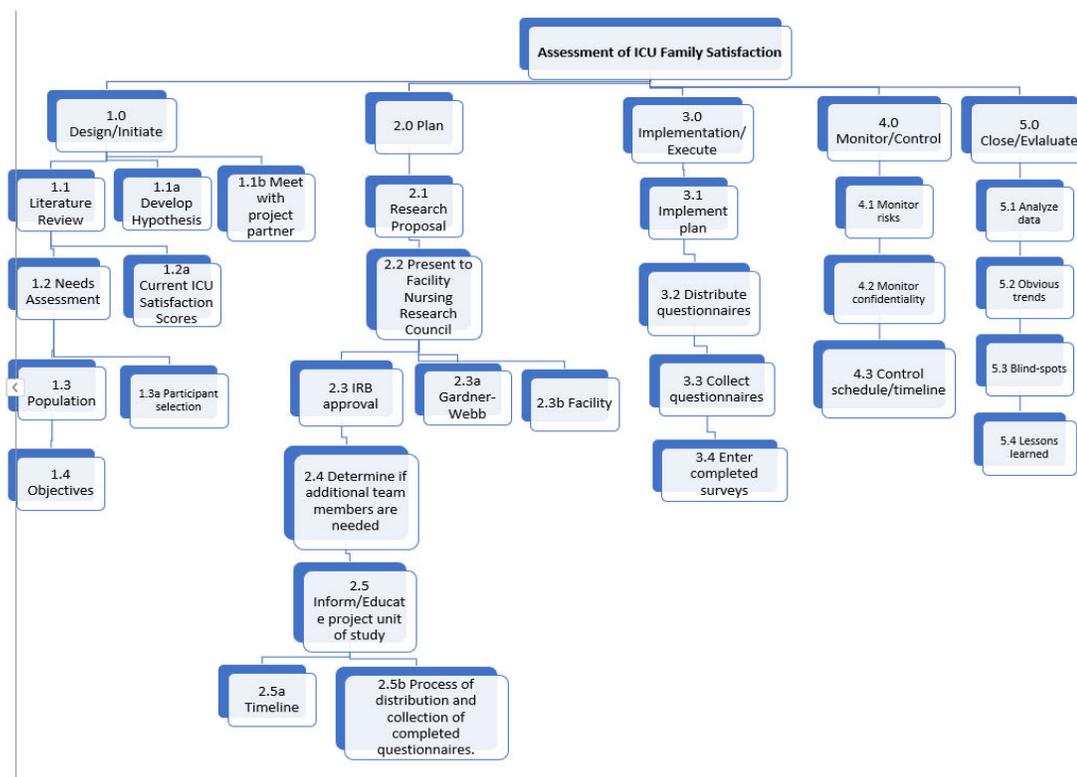
The success of any project depends upon the foundation. The Doctor of Nursing Practice (DNP) project includes elements of conceptual concepts and project management. The work planning that is completed before the start of any project must be well organized and include a timeline to keep the project and project investigator on track. Work planning provides structure to the DNP project by keeping necessary tasks on track and guides the plan to success.

Work Breakdown Structure (WBS)

Assessment of intensive care unit ICU family satisfaction DNP project is a quantitative study designed to survey family members of patient in a 22-bed, adult, specialty-ICU. The FS-ICU 24R is a rigorously researched, evidenced-based questionnaire designed to provide the health team with a family satisfaction summary of overall care, participation with care, and clinical atmosphere. The use of the FS-ICU 24R is one small step of many included within the project's WBS plan (Figure 3). The WBS plan provides a structured approach to detailed steps that must be completed before project implementation. The project investigator has the responsibility to develop a plan that breaks down each step into smaller steps to ensure each is achieved according to the established timeline (Harris et al., 2016). Implementation includes phase one actions with distribution of paper surveys. Phase one will be completed by March 2020. The WBS only includes plans for phase one completion since phase two and three will be completed after May 2020.

Figure 3

Each WBS step is broken down into sub-steps. While each level is independent of each other, some may occur parallel or in tandem.

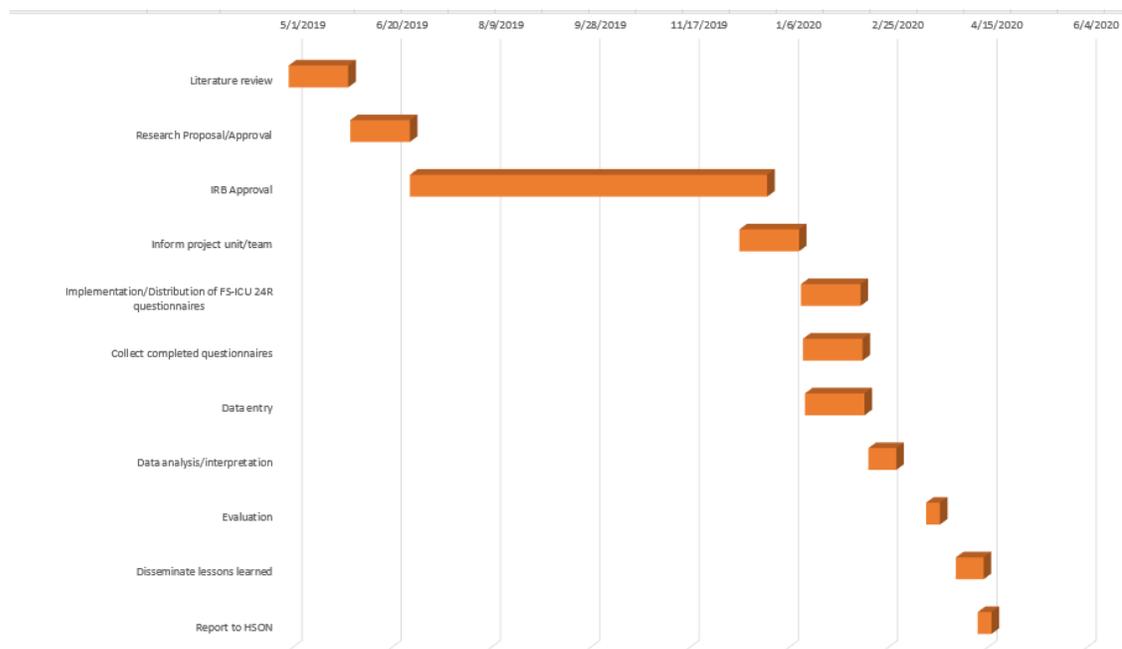


Timeline

The timeline for the assessment of ICU family satisfaction project is outlined in a Gantt chart (Figure 4). The chart provides the project investigator an estimation of time that each step may take. The project investigator can alter the steps as the project matures and timing is adjusted as necessary.

Figure 4

The Gantt chart lists each required task of the assessment of ICU family satisfaction project and keeps the project investigator on track.



Budget

The assessment of ICU family satisfaction practice project will have minimal costs. Use of the FS-ICU 24R questionnaire is no cost. Printing will come from the project facility copy center, and the indirect printing expense is included in the project unit's operating account. It will cost approximately 300 dollars for 300 copies of the FS-ICU 24R to be printed. Plans are to distribute the questionnaire on day three of the family's stay in the ICU or to the care partner when the patient receives transfer orders. The project investigator will distribute, collect, and enter the survey results. The cost for the benchmarking report and the lockbox for the returned surveys is the only predicted

direct cost. Indirect and direct budget details are listed in the project budget template (Figure 5).

Figure 5

Project budget for the assessment of ICU family satisfaction project contains both direct and indirect costs. Both types of costs are minimal.

EXPENSE BUDGET 7/27/2019

Assessment of ICU Family Satisfaction

Expense	Category	Budget	Actual	Difference (\$)	Difference (%)
Labor	Direct	\$ -	-	\$ -	-
Materials	Direct	\$ 300.00	300.00	\$ 300.00	100%
Lock box for returned surveys	Direct	\$ 50.00	50.00	\$ 50.00	100%
Cost for benchmark report	Direct	\$ 100.00	100.00	\$ 100.00	100%
Project Training	Direct	\$ -	-	\$ -	-
Project Unit space	Indirect	\$ -	-	\$ -	-
Internet	Indirect	\$ -	-	\$ -	-
Use of data management site	Indirect	\$ -	-	\$ -	-
Total Expenses		\$ 450.00	\$ 450.00	\$ -	100.00%

SECTION VI

Evaluation Plan

Family members will be surveyed for perception of care since they are present and assist the medical team in planning patient care. The FS-ICU 24R questionnaire is designed to be completed by a family member since patients don't often remember the ICU stay and cannot participate with care decisions. The evaluation plan is vital to the success of the FS-ICU 24R project by helping to determine if the family survey tool is an effective or ineffective way to measure ICU satisfaction.

Logic Model

Evaluation requires the use of a logic model. Data collection, statistical analysis, and benchmarking are used to interpret the findings. Logic models provide a systematic approach to describing the purpose of the project, the relationship between the problem and current practice, the desired change that is needed to make improvements, and the impact the project has on patient care (Zaccagnini & White, 2017). The logic model allows for changes to occur within the plan so that the best outcome is achieved (Zaccagnini & White, 2017). The logic model includes horizontal and vertical relationships between the associated project steps. Each step and objective can be changed at any time during the project. The purpose of the logic model is to maintain organization and timely project completion.

Project

The assessment of ICU family satisfaction project aims to find a reliable and sustainable way to measure ICU satisfaction accurately. The FS-ICU 24R is an evidence-based tool that is used internationally in ICUs all over the world. It has been proven as a

successful way to measure ICU satisfaction and has high reliability (Heyland et al., 2018).

Problem Identification

Current satisfaction surveys do not capture overall ICU satisfaction. Inpatient reports are completed by the patient and mailed after the patient is discharged. Most patients cannot recall the ICU experience and rely on family to interpret perception of care and treatments that are provided. Hospital financial reimbursement by the Federal Government is determined by inpatient unit satisfaction reports. In the ICU environment, the family is considered a vital team member and should be asked to evaluate the care received. Currently, the family is not surveyed, which leaves care evaluation to the patient who may or may not remember or can accurately recall the care received in the ICU.

Outcomes

In the Assessment of ICU family Satisfaction logic model (Appendix), the outcomes are identified by inputs, constraints, activities, and outputs. Short-term and long-term goals both impact outcomes and overall project impact, which is finding a sustainable and reliable method to measure ICU satisfaction. The assessment of ICU family satisfaction includes three phases with phase one being completed by May 2020.

SECTION VII

Implementation

Assessment of intensive care unit family satisfaction project achieved initial approval from the DNP project committee member, DNP practice partner, and the DNP practice learning environment. Partnerships chosen by the project investigator provided written approval to participate. The project investigator also submitted the DNP project proposal approval form, which was signed by the DNP project committee member chairman. Institutional Review Board (IRB) approval from the School of Nursing, the University, and practice facility were all obtained.

Survey Distribution

The project investigator distributed surveys to families of patients with transfer orders and with at least a three day stay in the project ICU. Participating family members who chose to participate signed an informed consent. A paper form of the survey was included for phase one of the project. The immediate next-of-kin or the patient's elected care partner completed questions 1-24 and 28-30 of the questionnaire without including any patient or family identifiers. Completion of the tool took approximately 15 minutes. Upon completion, the questionnaire was placed in a locked box that was placed at the front desk of the project ICU. Anonymous demographics obtained include sex, age, relationship to patient, any previous ICU family experience, place of residence, how often he/she sees the patient, and highest level of education. As the demographics were built into the approved tool, changes could not be made. The demographic information provides information as to the overall population served. This information can possibly assist in future implementation plans for further studies. Completed surveys were placed

in a sealed envelop and returned to a locked box by the participating family member completing the questionnaire.

Informed Consent

All participants signed an Informed Consent, which was attached to the first page of the paper family satisfaction questionnaire. Participation was on a voluntary basis. There were no personal health information or personal identifiers included in this study. The project investigator only has the right to view completed questionnaires. All completed paper questionnaires were kept in the project investigators locked office in a locked filing cabinet. When completed surveys are returned, the project investigator entered results into a password-protected computer.

Inclusion Criteria

A family member is identified as the immediate next of kin or the patient's elected care partner. The project investigator distributed the surveys on day three of the patient's ICU stay. The family member must be present to sign consent and complete the survey. Anonymous demographics obtained includes sex, age, relationship to patient, any previous ICU family experience, place of residence, how often he/she sees the patient, and highest level of education. As the demographics are built into the approved tool, changes cannot be made. The demographic information will provide information as to the overall population served. This information can assist in future implementation plans for further studies.

Exclusion Criteria

Exclusion criteria was any family of patient's who were transferred/discharged on day one or two, and families of patients that expire in the ICU. The patients with no

identified family were not surveyed. Transferred patient's families that were present during the non-working hours of the project investigator were also not surveyed.

Barriers and Threats

The project investigator encountered project barriers and threats during implementation. Twelve surveys were distributed with only seven returned during the six-week implementation period. Lack of family participation was the only foreseeable threat. Unforeseeable barriers included a shortened implementation timeframe from eight to six weeks due to having many patients in the ICU that only stayed one to two days. The project investigator was also in staffing two weeks during implementation due to changes in bedside staffing numbers. Many of the patient's families that would have been eligible had no family present on day three or no family that participated with care. Low ICU census below the maximum capacity of 18 was also encountered for 12 days during the implementation phase, which contributed to patients having shorter ICU stays. There were also patients transferred during the nighttime hours that the project investigator could not survey.

Monitoring of Implementation

Each research step was taken into consideration to measure progress against the established project goals, mission, evaluation, and timeline (Zaccagnini & White, 2017). The project investigator maintained positivity and leadership throughout the implementation phase and continued to plan for the future of the project by developing a more sustainable method of survey completion, data collection, and dissemination. The project investigator realized early into the project that one person cannot be solely responsible for survey distribution, which is why phase two has plans for electronic

survey completion. Phase three includes involving all adult ICU leaders for survey distribution and data collection in each adult ICU. Future planning includes a phase two and three for total project completion, which calls for transfer of knowledge, research, and lessons learned to other critical care leaders. Phase two and three of the assessment of ICU family satisfaction project will be completed after May 2020.

Project Closure

The project investigator met with the facility project partner at closure. Project success and potential shortcomings were discussed. Successes include having a way to determine what individual adult ICU satisfaction is currently. The project investigator presented all barriers and threats encountered throughout implementation and discussed how to present the data concisely to all stakeholders. There were no budget variances or unexpected expenses. Project highlights and dissemination to nursing leadership will include the assessment of ICU family satisfaction data of one ICU and how that translates into a sustainable way of improving the care provided to the ICU patient. Once phase two and three are completed, transfer of leadership will take place to provide a way to gather all adult ICU family satisfaction and a method to improve the quality of care provided to all ICU patients in the project facility.

SECTION VIII

Interpretation of Data

The project investigator used a password protected computer to enter all returned surveys into the REDCap electronic database system using a link that is specific to the project unit and organization. The FS-ICU 24R survey was voluntarily completed by families on day 3 of the ICU stay. Signed informed consent was also obtained by each participating family representative.

FS-ICU 24R Survey

The FS-ICU 24R measures satisfaction with care (14 items) and satisfaction with decision-making (10 items). In addition, three free-text questions ask how to make the ICU care provided better, what things the staff did well, and for any comments or suggestions that may be helpful. The FS-ICU 24R is completed by using a 5-point Likert scale: 1 = very dissatisfied, 2 = slightly dissatisfied, 3 = most satisfied, 4 = very satisfied, 5 = completely satisfied. This survey has a well-established reliability with a Cronbach a of 0.92 for satisfaction with care and 0.88 for satisfaction with decision-making. Distribution of answers is based on the average score of each response.

Quantitative Data

All returned and completed FS-ICU 24R survey answers are entered into the REDCap data management system. The data set was then exported to Excel for data analysis. The purpose of the project was to determine the current percentages of family satisfaction with care, family satisfaction with decision making, and overall family satisfaction. The project also highlights strengths and weaknesses around the care of the patient that are helpful when planning patient care quality improvement. Since the

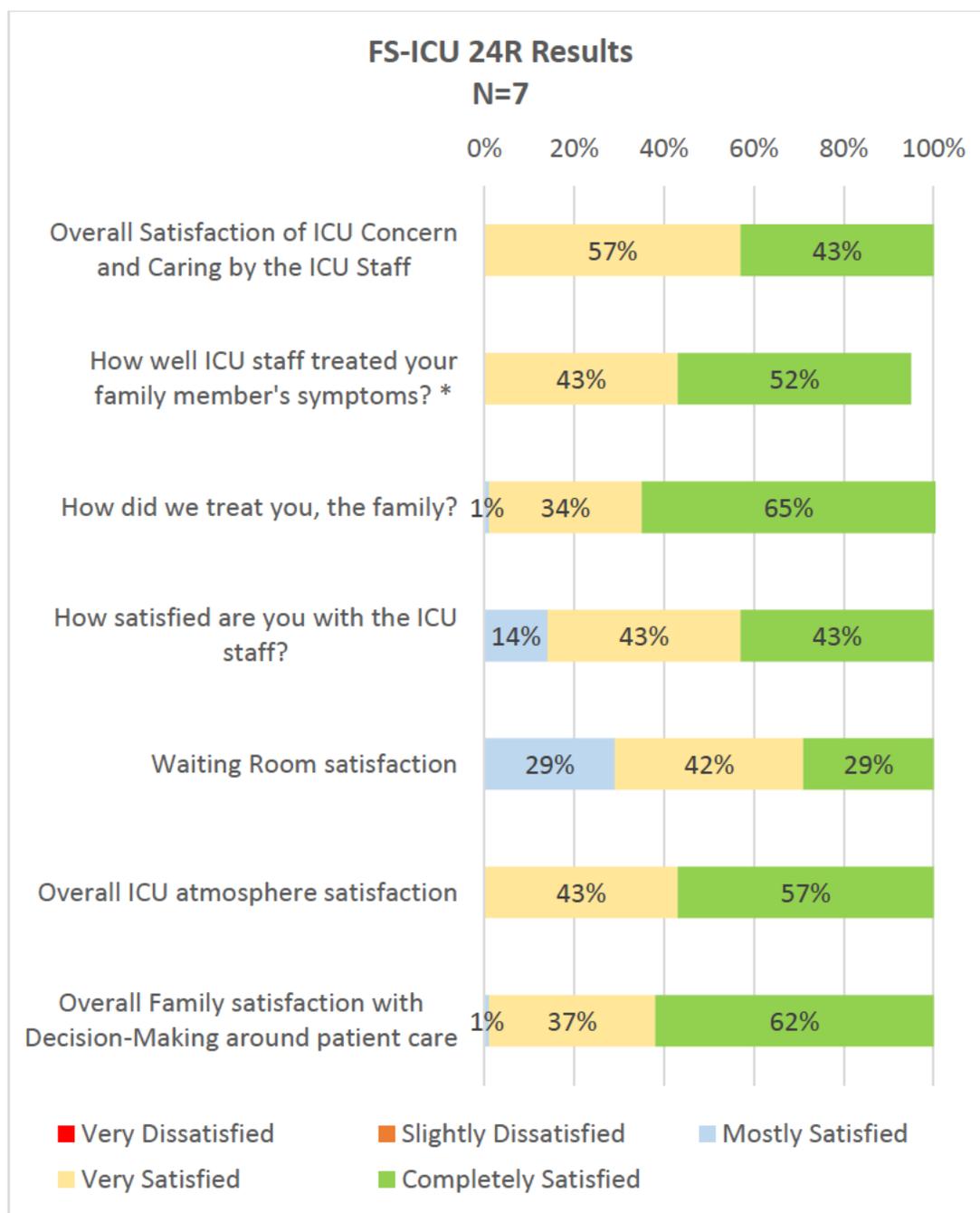
assessment of ICU family satisfaction project is a landmark study for the project facility and the project unit, the initial data helps to identify trends and patterns of what is working well and what opportunities for improvement exist.

Results

A total of seven surveys were distributed, completed by the next-of-kin, and returned to the locked box. The results are analyzed first by the FS-ICU 24R category major headings. Questions were answered by the next-of-kin with a Likert score of 3 (mostly satisfied), a Likert score of 4 (very satisfied), and a Likert score of 5 (completely satisfied). There were no answers scored with a Likert score of 1 (very satisfied) or a Likert score of 2 (slightly dissatisfied) (Figure 6). The results highlight the fact that most families are overall satisfied with the care received in the ICU, how well they were treated by staff, and decision making around patient care. Even though there were no scores below a Likert score of 3, the scores reveal there is work to do with improving family satisfaction with the waiting room.

Figure 6

FS-ICU 24R survey results for seven returned surveys.

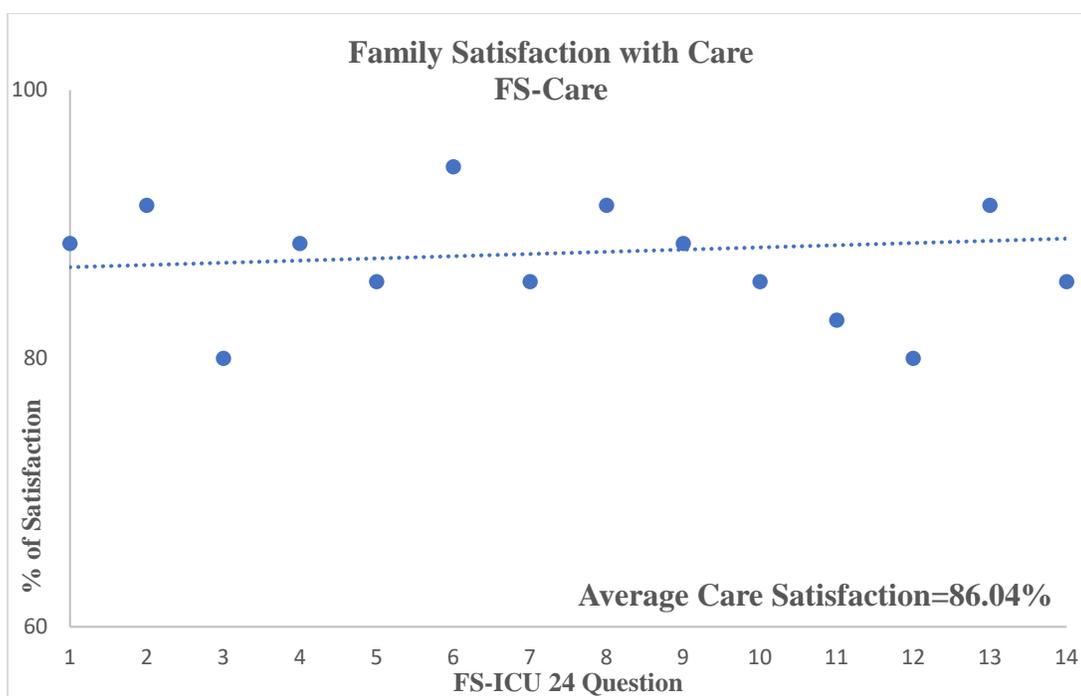


Note: Two participants did not answer question.

The Likert scale was then converted into a percentage scale with a score of 1=20%, score of 2=40%, score of 3=60%, score of 4=80% and a score of 5=100%. Each question was then given an individual satisfaction score. FS-ICU questions one through 14 determines family satisfaction with care (FS-Care) (Figure 7). FS-Care is determined to be 86.04%.

Figure 7

Family Satisfaction with Care Average of 86.04%

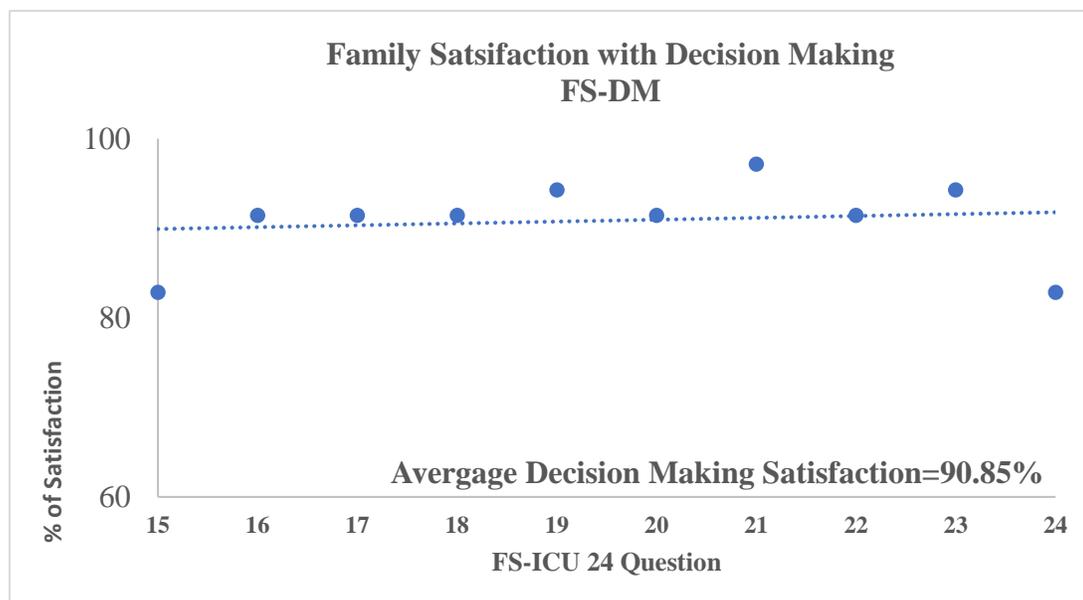


Questions 15-24 determine family satisfaction with decision making (FS-DM) (Figure 8).

FS-DM is determined to be 90.85%.

Figure 8

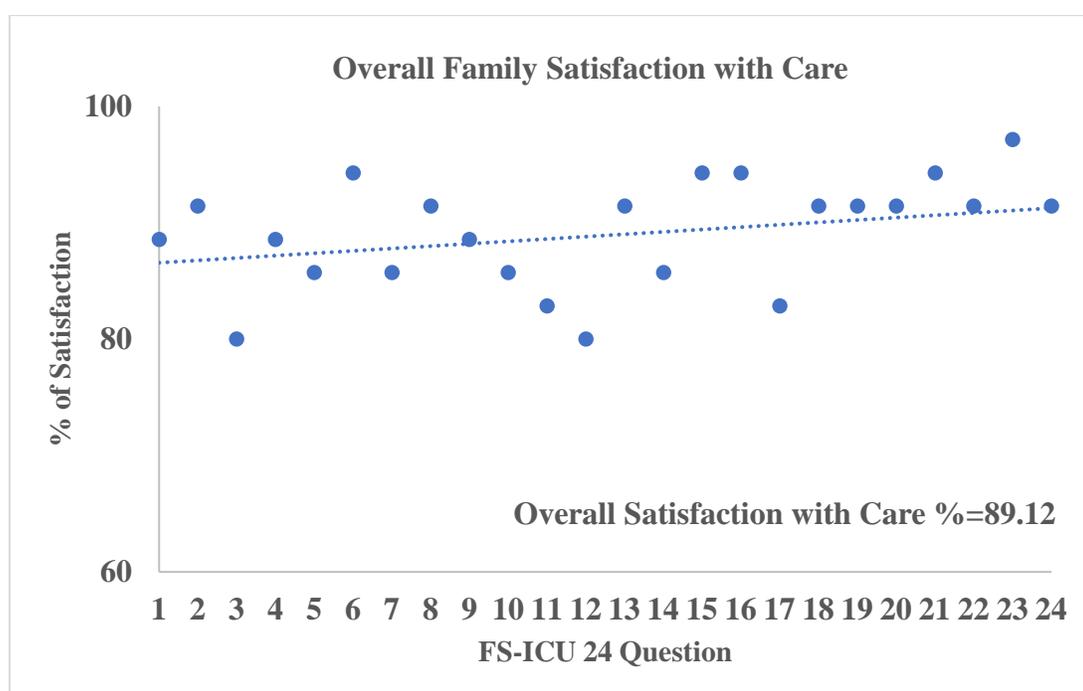
Family Satisfaction with Decision Making Average of 90.85%



The overall family satisfaction is a combined percentage of FS-Care and FS-DM (Figure 9). FS-ICU 24R questions one through 24 determine the overall family satisfaction with the overall care the patient received in the ICU.

Figure 9

Combined Satisfaction Scores of FS-Care and FS-DM to Determine the Family Satisfaction Overall Score of 89.12%



The FS-ICU 24R helps to highlight nursing team strengths related to ICU patient care: concern and caring by ICU staff, frequency of communication with ICU doctors, ease of getting information, and the feeling the family had control over the care provided to the patient. Even though there are no Likert scores lower than a 3 (mostly satisfied), weaknesses include consideration of family needs, daily MD rounds, and the family understanding of patient treatments and medications information.

Qualitative Data

The FS-ICU 24R contains three free-text questions that ask for family feedback regarding how to make the project ICU patient care better, what things the staff did well, and for any comments or suggestions that may be helpful (Table 2). Answers from the three questions reveal the same strengths and weaknesses as the FS-ICU 24R question analysis. Strengths are team related and around patient care delivery, while weaknesses include waiting room comfort and education provided to family regarding patient treatments and medications.

Table 2

Opinions About ICU Stay

Question	Feedback from FS-ICU Survey
Suggestions on how to improve the care provided in the ICU?	Better explanation of medication and treatments provided to patient.
Comments on things that went well?	The nursing team and staff were excellent. Went above and beyond to care for my family.
Suggestions on how to improve the ICU experience for the family and patient	More comfortable seating in the waiting room.

Note. The three FS-ICU 24R questions that allow for a hand-written response. Feedback is consistent with FS-ICU 24R scored questions.

Process Improvement

The FS-ICU 24R survey results allow for a baseline satisfaction performance percentage in the project ICU. Process improvement begins with dissemination of survey results to the ICU team. The nursing related improvement begins by developing a plan to maintain family satisfaction with concern and caring by ICU staff, frequency of communication with ICU doctors, ease of getting information, and the feeling the family

had control over the care provided to the patient. Improvement surrounds how to better explain patient care treatment and educate patient specific medication. Phase two of project will include an electronic version of the tool so families can complete the survey on a personal electronic device. This will allow for more surveys to be completed and returned, and therefore analyzed to determine satisfaction on a monthly basis. Phase three ensures project sustainability and for all adult ICUs in the project facility to use the FS-ICU 24R to determine family satisfaction with ICU patient care.

Conclusion

The assessment of ICU family satisfaction project is parallel to the mission of the project facility, which is to provide excellence in health. The FS-ICU 24R project reveals a sustainable way to capture, measure, and quantify the family's perception of care delivered in the ICU to make quality improvements in patient care. The project costs are minimal. Goals and objectives are written with a direct line of sight to succeed in proving that family perceptions of care provide a meaningful way to determine the quality of care delivered in an ICU. Watson's 10 caritas provide the support of the family satisfaction in the ICU project and allows for the health team to continue to improve patient care using a theoretical foundation. Although there was a small number of returned surveys, the results highlight family satisfaction with care, decision making, and overall care and treatment within the ICU setting. The project takes place in three phases. Phase one provides meaningful and specific feedback related to the family perception of ICU patient care and family decision making that aides in quality improvement planning. Phase two contains an electronic version of the FS-ICU 24R that will increase the number of returned surveys. Phase three supports the use of the FS-ICU

24R family satisfaction survey sustainability by implementing in all facility adult ICUs.

The patient is at the center of nursing and remains the focus of why the success of this project is vital to improve the care delivered in the ICU and to provide a sustainable way to properly plan continued improvement efforts.

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Appendix

Assessment of ICU Family Satisfaction logic model.

