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Incorporating Caring Competencies in the Academic Setting through Simulation

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by

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Abstract

Teaching caring, caring science, and the importance of caring competencies incorporated throughout the academic curriculum is vital in healthcare education. The purpose of this project was to increase the focus and importance of caring through didactic, interactive activities, and simulation experiences to promote the modeling and incorporation of caring competencies throughout the curriculum. Boykin and Schoenhofer's Caring Theory (2001) framework makes the assumption all persons are caring, and notes the caring relationship between the nurse/provider and the patient takes place in both actual practice and the simulated environment. A convenience sample of 32 first year ADN students enrolled in a Fundamentals of Nursing course participated in this study. Qualitative results revealed a new awareness of the importance and focus of caring competencies by students. The Caring Efficacy Scale (CES) was used for quantitative data revealing paired samples *t* test showing the mean for the pre CES (*M = 5.16*) implementation was slightly less than the mean for the post CES (*M = 5.39*). A paired samples *t* test ($t(30) = -8.06$, $p < 3.46$), indicated no significant difference between the pre and post CES aggregate means. The slight increase in caring efficacy at the end of the semester may reveal a new conscious awareness of caring competencies in first year nursing students. Other recent literature and the results of this study indicated clear evidence for incorporating caring best practices in any academic healthcare program. Caring competencies need to be implemented and incorporated throughout the didactic, clinical, and simulation curriculum.

Keywords: caring, caring behaviors, nursing education, caring in simulation, Boykin and Schoenhofer

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In Memory

Dr. John Richard Cheyne

(1929 – 2016)

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INTRODUCTION

Caring is often associated with healthcare professionals, yet the concept of teaching caring and the importance of caring competencies incorporated throughout the academic curriculum may be overlooked. Many people enter the healthcare field because of a passion to serve others, to care for people, or help make them better. Caring can encompass a multitude of services, and yet services rendered by healthcare professionals and measured by patient satisfaction surveys often reflect the caring behaviors exhibited by these professionals and felt by their patients, rather than technical skills or treatments professionals may administer (Manary, Boulding, Staelin, & Glickman, 2013). How the healthcare professional makes the patient feel, how empathetic and compassionate they were, is often linked to the positive impression of care or patient satisfaction. Manary et al. (2013) found patient-reported measures not only reflect patient evaluation of care-focused communication with nurses and physicians, they strongly correlate with better patient outcomes. Care-focused communication is further linked to federal reimbursement and the financial solvency of institutions (Wolf, Bailey, & Keeley, 2014).

According to Korhonen, Nordman, and Eriksson (2015), technology challenges the caring relationship between patients and healthcare professionals. Although healthcare professionals may desire to care, they are constantly challenged by time constraints and challenged to be competent users of new healthcare technology, which is growing and changing at warp speed (Huston, 2013). The fast pace focus on technologic competency for quality nursing practice and the dependence of the healthcare profession upon machine technology is significant to the practice of nursing and all healthcare providers, adding to the risk of depersonalization (Locsin & Purnell, 2015). These

challenges need to be overcome, or the human element of caring in healthcare will be lost.

SECTION I

Background and Significance

Problem Background

In the race to expand academic healthcare programs and teach more students, Huston (2013) recognized many challenges in integrating the caring aspects of healthcare with new technology and didactic demands. Academic programs are under constant pressure to teach nursing science and skills in a variety of pre-licensure formats, in addition to maintaining standards for accreditation and state regulated pass rates for licensure examinations. Measures for developing caring competencies should be added alongside knowledge, evidence-based practice, and informatics (Korhonen et al., 2015). As the demand for healthcare education increases, education has become modular with larger and larger cohorts, thus it can be argued that caring education may become a casualty of these changes (Costello & Haggart, 2009). Wolf et al. (2014) noted the strong association of patients' perceptions of nurse caring on the outcome of patient satisfaction with hospital services. Modeling caring behaviors and incorporating caring protocols throughout the academic experience may encourage caring behaviors in all nursing practice settings.

Significance

The purpose of this study was to incorporate caring competencies in the academic setting of the College of Health Sciences (CoHS) at the University. The greater mission of the University strives to embrace faith and intellectual freedom, balance conviction with compassion, and inspire a love of learning, service, and leadership (GWU, 2016). Along with this mission are the values of committing to self-giving service displayed in

Christ-like moral actions that respects the dignity and value of every person (GWU, 2016). Students are encouraged to provide compassionate and ethical care that is reflected in their attitude and approach to patient scenarios and interactions. The values and mission statements of the university and each program within the CoHS reflect Christian values; however caring competencies are not specifically named as a part of program mission, values, or objectives. Each healthcare program at the CoHS requires proficiency and high expectations for student performance. Developing a focus on caring behaviors in the patient relationship and implementing caring competencies throughout the CoHS programs may strengthen the importance of caring in the students' values and performances.

Many students enter academic healthcare professional institutions with a passion for caring for others. This project aimed to assist nursing students to improve caring behaviors and self-evaluation of caring after progressing through caring focused modules and simulations over a semester. The purpose of this project was to increase the focus and importance of caring through didactic, interactive activities, and simulation experiences to promote the modeling and incorporation of caring competencies throughout the curriculum.

Setting and Identified Need

The CoHS houses the School of Nursing (SON), the Physician Assistant Studies Program (PASP), and the Athletic Training and Exercise Science programs. Each program shares the greater mission and values of the University (Appendix A), but does not identify specific caring objectives, competencies, or measurable behaviors related to caring in any of the program or course objectives. No specific caring theorist has been

named to undergird the three healthcare programs within the CoHS. Inter-professional Education (IPE) components are now required by healthcare accrediting agencies, thus by incorporating a caring protocol through IPE simulation, each school will have opportunities to interact and develop caring behaviors towards patients, families, and colleagues, and develop a better team approach to communication and improved patient outcomes. This project will focus on pre-licensure Associate Degree Nursing students in the Fundamentals of Nursing course. In order to assess the need for caring science and caring competencies, the strengths, weaknesses, opportunities, and threats (SWOT) were performed. See Figure 1.

SWOT Analysis	
Strengths:	**Weaknesses:**
• In-house talent available • Experienced team members • Promotion of greater mission of GWU and CoHS • Openness to improve programs • Desire to include caring competencies • Willingness to incorporate caring competencies into curriculum • Promotion of IPE at GWU • Acceptance of a theorist to underpin CoHS • Supportive Deans	• Questionable contingency funding • Scheduling between schools in CoHS for student participation • Current faculty overload • Lack of participation by students or faculty • Lack of incorporation of caring competencies into curriculum • Time to incorporate caring competencies into curriculum
Opportunities:	**Threats:**
• Promotion of CoHS with caring focus • Graduating professionals with advanced caring focus • Increased opportunities for IPE • Promotion of CoHS programs, attracting students • Alliance with trends at GWU, North Carolina, and national healthcare academia which support caring education	• Competitors developing improved IPE experiences • Competitors having better simulation environments • Cost of GWU compared to competitors with similar IPE and caring competencies

Figure 1. SWOT Analysis

Magnitude of the Problem

To assess the presence of caring competencies and caring science within the CoHS, a simple questionnaire was sent to the faculty of the three programs. Approximately 30% of all full time faculty at the CoHS returned questionnaires, revealing a consensus of the importance and desire of incorporating caring and caring science into each program and course. The mission statements of some programs reflect caring aspects, such as developing caring knowledgeable and caring professionals; however, no specific caring science statements, caring theorists, or caring competencies are written as objectives or competency expectations within any of the three programs or any courses according to those responding to the survey. Each of the programs within the CoHS is accredited by professional agencies and graduating students have maintained exceptional professional licensure examination pass rates. The variety of integrated technology, simulation, and learning opportunities provide a competitive opportunity for students to learn with advancing technology. Students are well prepared academically to enter the healthcare environment; however, no evaluation of caring competencies has been implemented.

Impact of Problem on Organization

Academic healthcare programs which include caring competencies and strategies have been shown to increase recognition and demonstration of caring behaviors in healthcare providers (Greger, 2012). It is the hope that adding caring competencies and objectives to the programs and courses within the CoHS will promote caring behaviors within graduates and also uphold the University's mission: To embrace faith and intellectual freedom, balance conviction with compassion, and inspire a love of learning,

service and leadership. There is no guarantee students in programs grounded in caring philosophy will demonstrate and practice caring, however setting caring protocols and objectives in place will highlight their importance (Eggenberger, Keller & Locsin, 2010).

Team Selection and Formation

To best facilitate this project, the Doctor of Nursing Practice faculty assigned Dr. Gayle Casterline as chair of the committee. Dr. Casterline has extensive research and study in caring science and was a valuable asset for the project. Dr. Tracy Arnold, pre-licensure chair for the School of Nursing assisted as preceptor and Mary Holtschneider, Simulator Director at the Durham Veterans Hospital, was a committee member. Instructors in NUR106 and NUR107 (the lab portion of NUR106), Dr. Arnold, Mrs. Melissa McNeilly, and Ms. Brittany Hudgins, were consulted on a regular basis as portions of this project were implemented throughout the course and labs.

Defining the Scope of the Project

The ultimate purpose of this study was to incorporate caring competencies into the academic curriculum(s) of the College of Health Sciences (CoHS) at the University. Initially the project focused on the Fundamentals of Nursing course in the School of Nursing (SON), with the intent to expand caring competencies throughout the SON curriculum and other programs in the CoHS. The goal was to increase the focus and importance of caring concepts and behaviors through didactic, simulation, and modeling. In order to accomplish this, caring competencies were added or reworded throughout the curriculum. The final goal was to preserve the passion of these students as they enter their professional practice.

SECTION II

Literature Review

A literature review was conducted by searching a variety of databases and search engines. These databases included Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, Area Health Education Center (AHEC) digital library, Medline, and the search engine Google. Key terms for the search included caring, caring competencies, measuring caring, inter-professional healthcare students, health technology, and simulation.

Non-Empirical Research

With advancements in healthcare education and research on simulation based training, new standards of best practice continue to emerge. In addition to the National League of Nursing (NLN), the International Nursing Association for Clinical Simulation and Learning (INACSL) has set forth standards of best practice for simulation and simulation-enhanced inter-professional education. The Society for Simulation (2016) in Healthcare (SSH) is an accrediting body for simulation centers and qualifies educators and specialists with the Certified Healthcare Simulation Educator (CHSE) or Certified Healthcare Simulation Operation Specialist (CHSOS) certificates upon completion of qualifications and examination. As technology becomes a greater part of nursing and other healthcare professions, the integration of caring competencies needs to be addressed in every aspect of learning.

Caring

To increase the skill of caring and pedagogy of connectedness for nursing education, Garno (2010) recognized healthcare educators needed to increase the opportunities for caring and create conditions for internal self-discovery and care for

others through connectedness. Garno defined connectedness as “an immediate and total presence with another through a process of existential relating, transcending and reflecting” (p. 21). Through exploring and acknowledging the meaning of relationships with students, educators can teach connectedness and caring through practice and demonstration (Garno, 2010). Murphy, Jones, Edwards, James, and Mayer (2008) found nursing student’s perceptions of caring behaviors changed over the course of their academic studies, indicating decline in developing caring behaviors rather than an increase by the time of graduation. The educational process needs to improve and implement additional caring competencies and stress the importance of caring values to students and new graduates.

When healthcare professionals practice patient care grounded in caring theory, the healthcare provider has the ability to participate in the patient’s needs. Caring encompasses being there for the patient and responding to his or her needs regardless of the patient’s ability to reciprocate. Powers-Jarvis (2012) used Boykin and Schoenhofer’s Theory of Nursing as Caring to address whether the presence of a beating heart was a sufficient determining factor to consider a person as alive, and thus consider the influence of technology on caring. Technological advances have detected that patients in a persistent vegetative state may have the same basic physical capabilities as any other human being, although unable to communicate (Powers-Jarvis, 2012). Advancements in medical technology have promoted health and often sustained life but have often taken the focus off of the patient and onto technology, thus the need to re-focus on the human caring aspects of healthcare.

Simulation

Almost every aspect of daily life has been transformed by technology, and technology in health care is advancing dramatically, becoming virtual and more global (Cipriano, 2011). In 2011, United States Secretary of Health and Human Services, Kathleen Sebelius, issued the *National Strategy for Quality Improvement in Health Care* (Healthcare.gov, 2011), revealing a plan with three broad aims to reinforce the need for and improve health information technologies (IT) to improve quality of health. These three aims include: Better care, healthy people/healthy communities, and affordable care. With changing technologies and challenges in healthcare delivery, healthcare educators have been influenced by the impact of emerging technologies in the academic setting. To meet the growing competition for clinical learning, simulation centers have created learning environments to teach important skills, techniques, and competencies needed in professional practice.

In 2015 the National League for Nursing (NLN) released a living document: *A Vision for Teaching with Simulation*. According to the NLN, simulation provides a rich learning opportunity for students to integrate theory with practice in a realistic environment which poses no threat to patient safety. The National Council of State Boards of Nursing (NCSBN) conducted a landmark, multi-state, longitudinal study to explore the role and outcomes of using simulation in pre-licensure clinical nursing education (Hayden, Smiley, Alexander, Kardon-Edgren, & Jefferies, 2014). With conditions and training comparable with those in the study, it was concluded that up to 50% of traditional clinical experiences could be substituted with quality simulation.

Simulation based learning provides a realistic learning environment and experience for students and has positive effects on patient safety (Wegscheider, 2016). Simulation can be provided through standardized patients, low to high fidelity mannequins, and a virtual world (National League for Nursing, 2015). Using various methods allows students to interact in a realistic manner to practice and experience patient care situations along the continuum of care.

Simulation and Caring

Simulation has provided opportunities to practice and improve skills, assessment, critical thinking, patient safety, caregiver competencies, and many other valuable requirements of healthcare professionals today. With so much focus on the effectiveness and validity of simulation learning and the impact of emerging technology within healthcare professions, the art of caring has often been overlooked. With the critical demands for teaching nursing using simulation technology, Locsin (2005) developed the theory of Technological Competency as Caring in Nursing in order to recapture some of the caring emphasis. This theory challenges the student or practicing nurse to use technologies to know persons more fully and completely in the moment. Costello and Haggart (2009) believed caring education became a casualty of the demands upon healthcare educators to increase cohort enrollment and produce more healthcare providers. In order to address the importance of caring, simulation has become one avenue to promote and teach caring and empathy. Panosky and Diaz (2009) believed caring and empathy could be taught through simulation exercises, such as role playing and experiencing how a person may feel when given a life-changing diagnosis.

Technology need not negate caring. According to Diener and Hobbs (2012), technology should make caring all the more important. Diener and Hobbs thought caring was relational and a learned behavior acquired primarily through modeling and expressed through the being mode of caring as presence and connection. The authors believe in order for caring relationships to be formed, a caring presence needs to be enacted. Thus transpersonal caring requires reciprocity, which is not developed between students and simulated patients. Diener and Hobbs (2012) used reflective activities after simulation experiences to promote awareness of caring during simulation activities.

Contrary to Diener and Hobbs (2012), Greger (2012) believed the art of caring and the science of technology could be united to achieve true quality patient care. In order to accomplish this, healthcare educators must emphasize the caring relationship and incorporate it throughout their programs. With the use of Swanson's Theory of Caring and Locsin's Theory of Technological Competency as Caring in Nursing, Greger promoted instructional strategies for nurse educators to foster and enhance caring behaviors. Simulation takes on various forms, from high-fidelity simulators to standardized patients, all of which can provide a very real experience for the student when employed with realism. The use of simulation with a focus on reflection during debriefing and confluent caring education strategies can bring about a deepening of caring behaviors with an impact on patient outcomes (Greger, 2012). There is a potential danger within the healthcare industry to become fixated on technology and become robotic in nature. The use of Locsin's theory promotes knowing the whole person by consciously acknowledging the challenge to seek meaningful and appropriate ways of

practice, including the appropriate use of technology to understand and care for the patient (Greger, 2012).

If technology in healthcare is to improve quality patient care outcomes, then caring for the patient is the foundation of this relationship (Hill, 2013). The patient needs to remain the priority as technology continues to evolve, thus technological competence can allow the healthcare provider to provide a caring environment while caring for the patient (Hill, 2013). Boykin and Schoenhofer's (2001) caring theory describes people as being caring based on their values and virtues as human beings and on recognizing people as whole and complete in the moment. Similar to previous authors, Hill (2013) explained that meeting the needs of the patient requires maintaining focus on the patient while integrating technology as a tool to provide care.

To address this further, Korhonen, Nordman, and Eriksson (2014) conducted a systematic analysis of the ontology of the concept of technology from the perspective of caring science. They found, in spite of its many advantages, technology can be intimidating, complicated, and even oppressive. In these instances, the essence of caring and human dignity may not be realized (Korhonen et al., 2014). However, the authors believe that it is possible to teach the use of technology in the caring process (Korhonen et al., 2014). They also felt technology can be seen as equipment, systems, or devices, and the use of technology and delivery of care through technology, can be used in alignment with caring science. Some difficulty in translation of caring terms and cultural awareness became apparent in their project, thus only English dictionaries and dialogue were involved. Using only one language definition of terms limited some variety and meaning of the concepts of caring and technology. The authors concluded caring science

is often open to scrutiny, yet vital to human nature, and new knowledge and deeper understanding of the substance and application of caring science will continue to be researched.

In 2015 Korhonen, Nordman, and Eriksson extended their study of technology and its ethics through an integrative literature review of caring in nursing and caring journals. The articles collected from 2000 to 2013 focused on the concept and the ethical use of technology in caring and nursing journals. This review revealed three implications from the concept of technology: technology is devices and products; technology refers to a process consisting of methods for helping people; and technology as a service may indicate some production of care (Korhonen et al., 2015). The ethics of technology was found to be diversely described as a concept and it has not been established as a guiding principle. Although there is some evidence caring science may be delivered through technology, more is needed to promote ethical care with the use of technology.

To advance the theory of technological competency as caring in nursing, Locsin and Purnell (2015) continued to develop the theory of Technological Competence as Caring in Nursing (TCCN). To demonstrate the fundamental process of knowing persons within the universal technological domain, Locsin and Purnell used three key elements: Technological knowing, designing, and participative engaging. The nursing concepts of human naturalness, human wholeness, and nursing technology connoisseurship are used to support this process. To appreciate and know patients more fully as active participants in their care, rather than as passive recipients, advances the preservation of humanness (Locsin & Purnell, 2015). Technology will continue to advance in diverse environments of care, thus healthcare providers will need to demonstrate the universality of the

technological domain and implement the theory of TCCN in many healthcare related environments. Some implications for nursing and all healthcare providers is the challenge to know persons more fully as human beings rather than objects of care, thus maintaining and sustaining their humanness. As a uniquely human service, it is critical for all healthcare providers to maintain the influence of technological competency as caring.

Interprofessional Simulation and Caring

As an example of the importance of developing interprofessional education, faculty at the University of Toledo developed the Interprofessional Immersive Simulation Center (IISC), 2016 to train healthcare professionals using simulation to positively impact patient safety and improve the quality of care. Using simulation models, simulated clinical settings, and 3D Virtual Immersive Environments, this center serves as a hub for innovation and fostering partnerships with industry to create and develop new products, processes, and procedures to enhance patient care. The Interprofessional Education Collaborative (2011) developed the Interprofessional Collaborative Practice (ICP) with core competencies for inter-professional collaborative practice to meet the growing demands of healthcare transformation. Using these core competencies will assist in preparing all health professional, students, and meet requirements of healthcare education accrediting bodies. Learning in this type of creative environment and connecting healthcare professionals at various learning stages allows for various competencies and attributes, such as caring, to be practiced in a productive manner.

Empirical Literature Review

Teaching Caring in Nursing Education

Although caring has historically been associated with the healthcare profession and with the field of nursing in particular, recent research is bringing to light the importance and influence of teaching caring behaviors to all healthcare providers early in educational programs. Blum, Hickman, Parcells, and Locsin (2010) led a quantitative research study to examine the influence of teaching caring nursing on the caring behaviors of practicing registered nurses (RN's) attending a Bachelor of Nursing Science (BSN) course. Using a 42-item version of the Caring Behaviors Inventory (CBI) designed by Wolf, Giardino, Osborne, and Ambrose in 1994 to define the construct of caring, the researchers found all 42 caring behaviors exhibited mean increases from the beginning to the end of the course. Overall total nurse caring behaviors showed a significant increase of 12% following the intervention (Blum et al., 2010). However, using only a small sample of 19 RN-BSN students in a single program may have limited the diversity and range of healthcare professionals needed to show a significant increase in caring behaviors throughout academic programs and educational levels of students. It was suggested that further research take place along with implementation of caring competencies in the academic setting and reinforcement during professional development.

In a similar study, Sokola (2013) used a descriptive correlational design to study a convenience sample of associate degree nursing students from a community college in a Mid-Atlantic state. The goal was to determine the relationship between caring ability and competency with caring behaviors and the difference in caring ability of first and fourth

semester nursing students. Some of the 119 students were in the first semester, while others in the fourth semester of clinical courses. The research was guided by the work of Mayeroff and the nursing theories of Leininger, Watson, and Boykin and Schoenhofer. Sokola used each of the innate caring abilities of all individuals that develop over a lifetime as a base for the study. She found that although students may have innate caring abilities, caring can be learned through education. A positive relationship was found between caring ability and competency with caring behaviors for the first semester students. First year students indicated an ability to care, but did not perceive they had the clinical competence to build trust in the nurse-patient relationship. Higher perceptions of caring ability were reported by nursing students with a higher perception of competency with professional caring. According to the author, students responding to the self-report instruments may have answered what they believed they should have answered, thus this study was only able to examine a narrow aspect of caring (Sokola, 2013). Nursing education significantly impacts the development of professional caring behaviors but may not have an effect on innate caring abilities.

Caring in Professional Settings

Caring behaviors are being studied in the professional setting as well. Using Swanson's caring theory (1991) of knowing, being with, doing for, enabling, and maintaining beliefs, Amendolair (2011) used a qualitative approach to interview acute care nurses in one community hospital. Nurses expressed negative feelings about not being able to spend time with their patients and care for them in the way they desired. Some nurses felt they became more caring as a result of the study. The use of inexperienced interviewers with limited training may have limited the consistency and

validity of findings. The researcher suggested continued development of Swanson's Theory of Caring (1991) through educational videos and additional courses throughout the healthcare facility. A longitudinal study was planned to measure the effect of caring education on patient satisfaction of nursing care (Amendolair, 2011).

In 2012 Amendolair examined the relationship between nurses' expression of caring and job satisfaction. Nurses report they do not have time to express caring behaviors which impacts meaning, value, and satisfaction in their work (Amendolair, 2012). The author randomly selected 5,000 nurses out of a sample of 12,000 registered nurses working in acute care medical surgical units in North and South Carolina. The nurses were sent two valid and reliable instruments: the Caring Efficacy Scale (CES) and the Index of Work Satisfaction (IWS). There was a 22% response rate (N = 1,091). There was a positive correlation between the CES and the six components of the IWS ($r = 0.276$, $p = \leq .01$).

Academic settings and institutions alike are concerned about healthcare consumer satisfaction. Griffiths, Speed, Horne, and Keeley (2012) conducted a study at the University of Manchester in the United Kingdom to understand what healthcare service users (patients) and care givers are looking for in graduate nurses and what challenges exist for educators to prepare these students. The researchers systematically analyzed and compared the transcribed interviews from 52 healthcare service users. Patients looked for technical competence and knowledge from healthcare providers, along with the willingness of healthcare providers to seek additional information when needed. However, the overwhelming priority concern for patients was a caring professional who displayed an empathetic attitude, non-judgmental communication skills, and provided

patient-centered care (Griffiths et al., 2012). In addition, participants raised questions about educational programs and questioned the ability to teach caring in academic settings. Many participants expressed a strong desire to have healthcare providers return to the caring of the past. The researchers concluded that reviewing standards and new curricula are necessary to ensure qualities of caring are incorporated in the academic and institutional healthcare setting. Although this study had adequate participants to saturate data for a qualitative study, the participants were self-selected through a support group from one community and thus may have been more proactive, according to the researchers.

In order to develop caring protocols at the National Cancer Institute Comprehensive Cancer Center (NCICCC), Wolf et al. (2014) identified critical caring elements through an interventional study on nurse caring. Initial research from published articles on caring programs along with their instruments were analyzed for caring patterns and behaviors or activities representing nurse caring which could contribute to a caring intervention. The framework for this research was the nurse service organization's mission and vision, guided by Watson's Caring Theory (2009) and other caring theorists. Their mission and vision emphasized compassion, caring, collaboration, evidence-based practice, and patient safety. The researchers created caring interventions as a part of the program and measured patient satisfaction as the outcome variable. The researchers also hoped a caring protocol would foster collaboration among inter-professional healthcare providers across the institution. Results of the 119 caring activities were sorted into five clusters: respectful, connectedness, knowledge and skill, assurance, and attentiveness. Each cluster was assessed for interrater reliability, leaving 108 caring activities for the

protocol. The caring constructs included: respectful (courteous regard for the other); knowledge and skill (nurse caring as proficient, informed, and skillful); connectedness (optimistic and constant readiness on part of nurse to help the other); assurance (investment in other's needs and security); attentiveness (appreciation of and engrossment in the other's perspective and experience); and collaboration (engagement in collegial, interdependent partnership) (Wolf et al., 2014). To implement these protocols, a teaching plan was created along with reminders of these strategies and action plans. Limitations of this study include a lack of clear evidence of improvements after implementation of caring protocols and the researchers' interpretation of related caring literature. By determining patterns of caring activities, this study identified critical elements on nurse caring and developed caring protocols.

Teaching Caring Through Simulation

To assist healthcare educators to meet the growing demands of teaching, simulation programs have become an important component of the academic setting. Through a meta-synthesis Gonzalez et al. (2010) evaluated the effectiveness of teaching caring in a simulated environment. According to the researchers, many attempts have been made to teach caring, however overall caring remains on the fringe of simulation teaching, while skill proficiency seems to prevail as the main focus in nursing education. According to the authors, many studies revealed the positive effects of simulation to help students gain confidence, skills and some communication skills, but fall short of addressing the impact of caring behavior on patient care. Thus future studies were recommended to fill this gap in teaching caring behaviors through simulation (Gonzalez et al., 2010).

Valuing caring behaviors, Eggenberger et al. (2010) conducted a qualitative focus group study on a purposeful sample group of 77 nursing students in an adult acute care course. Two main objectives of the study were to describe how students come to know the person being nursed as caring and second, to explore how caring is expressed within an emergent nursing situation using a high-fidelity simulator. Using a caring teaching framework and simulation practices of pre-briefing, encountering and debriefing, a simulated experience was developed and analyzed. The researchers identified words, phrases, and statements describing how students grounded nursing actions in caring in emergent situations. Carper's fundamental patterns of knowing in nursing (empirical, aesthetic, ethical, and personal) were used to organize the data (Carper, 1978). Eggenberger et al. (2010) concluded it is possible for students to value caring behaviors within emergent situations, and there is the potential to evaluate caring behaviors in simulated nursing situations.

In a later study, Eggenberger, Keller, Chase, and Payne (2012) used a quantitative approach to evaluate caring in nursing simulation. Based on components of Jefferies and Rogers (2007) framework for nursing education and simulation, the researchers used an innovative approach for grounding nursing simulation. To link between reality and caring, this study used the framework of Boykin and Schoenhofer's caring theory (2001), which makes the assumption all persons are caring, and notes the caring relationship between the nurse and the patient takes place in practice and in the simulated environment. The researchers compared faculty ratings of students and student self-ratings on caring efficacy during an adult acute simulation experience. The sample was 57 traditional and accelerated baccalaureate nursing students within a program grounded

in caring theory. Students rated themselves as slightly or moderately capable of caring, along with faculty scoring students with similar ratings. The sample was too small to support a factor analysis for adapted instruments and some students indicated difficulty in suspending belief or treating the simulator as a real person. The researchers felt that research with different types of scenarios and further development of the instruments to measure caring is necessary, and that as the use of simulation in healthcare education increases, the opportunity to learn and practice caring attributes in the simulated environment will be important.

Simulated clinical experiences provide an ideal opportunity to practice, review and learn, yet, developing a tool to evaluate caring can be challenging according to Brown, Garnett, Weiss, and Newman (2013). The researchers measured four simulated clinical experiences of two groups of advanced practice nursing students from one program over a two semester time period. Roach's (2007) six caring behaviors were assessed to determine promotion of caring behaviors: compassion, competence, confidence, conscience, commitment, and comportment. The 57 students who participated in the study were randomly chosen to play a part in various roles during the simulated experiences. The researchers used the International Nursing Association for Clinical Simulation and Learning (INACSL) (2013). Standards of Best Practice for simulation to guide the simulation experiences and an adapted Kolb's Experiential Learning Cycle for their study. A Caring Evaluation Tool (CET) was designed to address the affective, cognitive and psychomotor skills involved in simulated clinical experiences. Quantitative data and qualitative data from written student comments were analyzed. A pattern was noted with higher caring scores at the beginning followed by a

fall in caring scores at the end of the first semester, a slight rise at the beginning of the second semester with another fall by the end of the second semester. Findings mirrored patterns found in educational literature which show as students learn more about caring and their own abilities, they can more accurately self-identify their own level of caring and the need to improve. Brown et al. (2013) noted caring is often shortchanged in developing healthcare management and other competencies in healthcare fields and needs to be emphasized to a greater extent. Further studies with similar caring tools in a variety of healthcare programs are suggested. In conclusion, the researchers found simulation provided an ideal opportunity to emphasize and evaluate caring behaviors, recommending further integration of caring components in simulated clinical experiences.

Simulation is also used to enhance caring behaviors and empathetic responses to specific health issues. To enhance the development of empathy, Chaffin and Adams (2013) used a hearing voices simulation to enable nursing students to experience auditory hallucinations, which may affect patients with schizophrenia. This study used a convenience sample of 67 senior baccalaureate nursing students in a state college in Nevada enrolled in a mental health course. Quantitative data was collected from an evaluation form completed after the simulation and qualitative data obtained from open-ended questions designed to generate reflections of the experience and its impact. Pre- and post-simulation measures of empathy were analyzed, finding a significant improvement ($p < .001$) in students' empathy and reflective statements showing student attitude changes as a result of the experience. The majority of students described newly acquired empathy, increased understanding, and expressed positive transformation by the

experience. Students and faculty reflected that the simulation provided a valuable experience and should not only continue in their program, but be added to various programs in healthcare to promote caring, particularly in mental health.

A similar study promoting caring and empathy in nurses conducted by Diaz, Maruca, Kuhnly, Jefferies, and Grabon (2015) focused on the lived experiences of student nurses wearing an ostomy appliance for 48 hours in a clinical simulated experience. During a fundamentals course, 135 baccalaureate nursing students were asked to wear an ostomy appliance, correctly located anatomically and filled with simulated contents, for 48 hours. Students wrote reflections about feelings evoked related to the ostomy. Data was analyzed by the researchers, identifying empathetic statements and themes. The main themes emerging from the data included: The impact on body image was immense; "I can see now and empathize with future patients"; a feeling of enlightenment; the experience disrupted relationships; and a feeling of anxiety about what to do if the experience was real (Diaz et al., 2015). The following key points were made by the researchers: teaching empathy and caring to nursing students is important to their clinical practice; the use of experiential simulation is an effective pedagogical strategy to teach empathy to nursing students; and simulation was an effective method to enhance caring and empathy in nursing students that can translate into practice. This study supports student's retention and application of information learned in simulation may influence clinical practice and improve patient outcomes (Diaz et al., 2015).

Enhancing caring and empathy may be more complicated when simulating experiences of caring for patients during the final stages of life. Nurses often report inadequacies in providing end-of-life care and experienced anxiety about death (Lippe &

Becker, 2015). In addition, in a survey of deans and directors from accredited nursing programs in the United States, only 3% offered courses dedicated to end-of-life care in their curricula (Lippe & Becker, 2015). Teaching about end-of-life care may enhance a student's knowledge and skill. However having a simulated practical experience provides the opportunity to reflect and begin to gain an understanding into personal feelings about mortality. Lippe and Becker (2015) designed a study to assess achievement of student learning outcomes during a simulation on a critically ill patient from whom care is ultimately withdrawn. In the simulation, students cared for a critically ill patient whose condition quickly deteriorated from critical to terminal. A pre- and post-test design was used to assess changes in students' attitudes and perceived competence for end-of-life care over time. Three cohorts, totaling 118 baccalaureate nursing students, participated in the study. Of the three cohorts, one cohort participated during a critical care elective course and two cohorts during a final adult health clinical course. Perceived competence and attitudes in caring for dying patients were measured at baseline and at completion of the simulation. Results of the study showed improved perceived competence in all three cohorts and two cohorts exhibited more positive attitudes toward caring for dying patients after the simulation experience. It was unclear if simulation alone improved attitude changes rather than the general program and other clinical experiences, however simulation was believed to be an effective teaching strategy contributing to the practice of compassionate care (Lippe & Becker, 2015).

Interprofessional Simulation

Simulation has become a key element in inter-professional education and collaborative practice where it is seen as key in achieving safe, high quality, accessible

patient-centered care (Interprofessional Education Collaborative, 2011). Mckay, Sanko, Shekhter, and Birnbach (2014) studied inter-professional teams during self-debriefing after simulations in a week-long inter-professional simulation-based safety course at the University of Miami. Dividing 144 third year medical students and 60 second semester nursing students into 29 teams, each team participated in a simulation encounter and debriefed themselves afterwards. To foster student engagement, students and faculty participated in Twitter conversations throughout the week. Twitter, a social media, successfully captured a "behind the scenes" conversation and the experiences of the students which would have not been otherwise captured. This qualitative data was analyzed along with observations of student interactions. Most participants felt a freedom to speak freely compared to faculty lead debriefing and learned more about fellow healthcare professionals. This information continues to be used to guide interprofessional programming in both the University of Miami medical and nursing schools. Additional research exploring the impacts and perceptions of self-debriefing is recommended to fully evaluate the benefits and limitations of this approach to debriefing.

The following year at the University of Miami School of Nursing and Health Sciences, Sanko (2015) explored the cohesion and performance relationship within inter-professional teams during a simulation exercise. The researcher divided a convenience sample of 200 nursing and medical students into 29 teams and implemented a series of multi-patient simulation encounters during the semester course. Team cohesion was measured at two time points, day two and post-course. Team performance was measured by communication, time of task completion, and associated errors. Day two cohesion was found to predict post course cohesion ($p < .001$) and team performance ($p = .010$), no

differences in cohesion by gender or intended profession were found. Results of this study demonstrated a positive relationship between cohesion and performance in healthcare teams.

In another study addressing inter-professional knowledge and communication, Tofil et al. (2014) recruited third-year medical students and senior nursing students for four one-hour simulations. After each scenario, experts in medicine, nursing, simulation, and adult learning facilitated debriefing sessions. Pre- and post-tests assessing self-efficacy, communication skills and understanding of each profession's role were measured. Self-efficacy communication scores improved for both medicine (18.9 $\pm$ 3.3 pretest vs 23.7 $\pm$ 3.7 post-test) and nursing (19.6 $\pm$ 2.7 pretest vs 24.5 $\pm$ 2.5 post-test). Results of this study revealed improvements in self-efficacy, communication, and confidence to correct another healthcare provider in a collaborative manner.

Summary of the Literature

The importance of caring in healthcare practices cannot be over emphasized. With the fast pace of advancements in technology and the rigorous requirements in any healthcare academic field, it is critical to incorporate core values and the competencies of caring. Evidence found in literature identifies a large gap in health care education with caring and attention to the humanistic side of patient care during the instruction and implementation of new technology (Korhonen et al., 2015). McGrath (2008) found experienced critical care nurses were generally able to manage extensive technology and deliver expert caring to their patients, however, novice nurses had difficulty in caring while handling technology. It is recommended that more emphasis be placed in the academic fields to teach ethical caring along with the use of technology (Korhonen et al.,

2015). It is paramount to intentionally incorporate objectives and structure activities that encourage caring competencies to prepare healthcare professionals to maintain these practices.

The ability to know the patient in his or her own sense of reality, or in the moment of need, is the basis of both Swanson's Theory of Caring (1993) and Locsin's Theory of Technologic Competency as Caring in Nursing (2005). Investigating the effectiveness of using high-fidelity simulated patient care interactions to teach caring behaviors to nursing students, Blum et al. (2010) found a significant increase in the student's ability to recognize caring behaviors. Panosky and Diaz (2009) demonstrated simulation promoted increased caring behaviors and empathetic understanding of the patient's situation. To stress the importance of connecting with patients, Storr (2010) investigated the effectiveness of using role-play in simulation training with students. Eggenberger et al. (2010) found simulation situations to be ideal for evaluating caring behaviors in healthcare students and faculty. Simulation experiences have been shown to improve the ability of healthcare providers to empathize or demonstrate caring behaviors when offering care to patients with a specific illness or assist a patient through a transition such as adjusting to an ostomy (Diaz et al., 2015).

The literature indicates clear evidence for caring best practices in any academic healthcare program; caring competencies need to be implemented and incorporated throughout the curriculum, in didactic lecture and clinical practice experiences including simulation. The goal of incorporating caring competencies to promote caring professionals starts with the innate caring characteristics in healthcare students, then enhancing and maturing additional caring behaviors. Starting with the fundamental

practice skills course, then adding caring components throughout the curriculum, the nursing art of caring literacy will be modeled, learned, rewarded, and deeply appreciated as a strategy for improving the quality of life for patients, families, and nursing staff, as well as students and nursing faculty.

SECTION III

Theoretical Underpinning of the Project

Theoretical Framework

Boykin and Schoenhofer's (2001) theory of Nursing as Caring served as the theoretical framework for this project. Boykin and Schoenhofer's theory has been used in a variety of settings to guide academic and healthcare organizations and is based on the work of two caring scholars, Mayeroff and Roach (Boykin & Schoenhofer, 2001). Other caring theorists such as Watson, Ray, Leininger, and Gaut are also credited with their influence upon Boykin and Schoenhofer. The major assumptions of Nursing as Caring (Boykin & Schoenhofer, 2001) include:

1. Persons are caring by virtue of their humanness.
2. Persons are caring, moment to moment.
3. Persons are whole and complete in the moment.
4. Personhood is a process of living grounded in caring.
5. Personhood is enhanced through participating in nurturing relationships with caring others.
6. Nursing is both a discipline and a profession.

Although Boykin and Schoenhofer's focus is on the nursing profession, the belief that all persons are caring by virtue of their humanness establishes the ontological and ethical foundation of this theory, and can be used for all healthcare professions.

Locsin (2005) believed the concept of human being as whole in the moment is expressed moment by moment because human beings are unpredictable and ever-changing. Technological Competency as Caring in Nursing is a middle range theory

developed by Locsin (2005) and grounded in Nursing as Caring (Boykin & Schoenhofer, 2001). Assumptions of the theory are:

- Persons are caring by virtue of their humanness (Boykin & Schoenhofer, 2001).
- Persons are whole or complete in the moment (Boykin & Schoenhofer, 2001).
- Knowing persons is a process of nursing that allows for continuous appreciation of persons moment to moment (Locsin, 2005).
- Technology is used to know wholeness of person's moment to moment (Locsin, 2005).
- Nursing is a discipline and a professional practice (Boykin & Schoenhofer, 2001).

Locsin's (2005) theory of technological competency as caring in nursing occurs when caring and technologies coexist and harmonize to bring about better patient outcomes. Deliberate and continuous use of technologies for the use of knowing persons refocuses not only the profession of nursing, but of all healthcare professionals to improve their knowledge of persons through the competent use of technology. Caring is critical to fully appreciate, know, support and affirm a fellow human being in the moment.

For the purposes of this project, Boykin and Schoenhofer's concepts of persons are caring by virtue of their humanness and caring behaviors were utilized. Persons are identified as first year Associate Degree Nursing (ADN) students participating in two simulation-based learning experiences, three short didactic lectures and an on-line case study. Caring was measured by the student's score on the Caring Efficacy Scale (CES)

(Appendix B). These concepts are diagrammed in the Conceptual, Theoretical, and Empirical (CTE) structure in Figure 2.

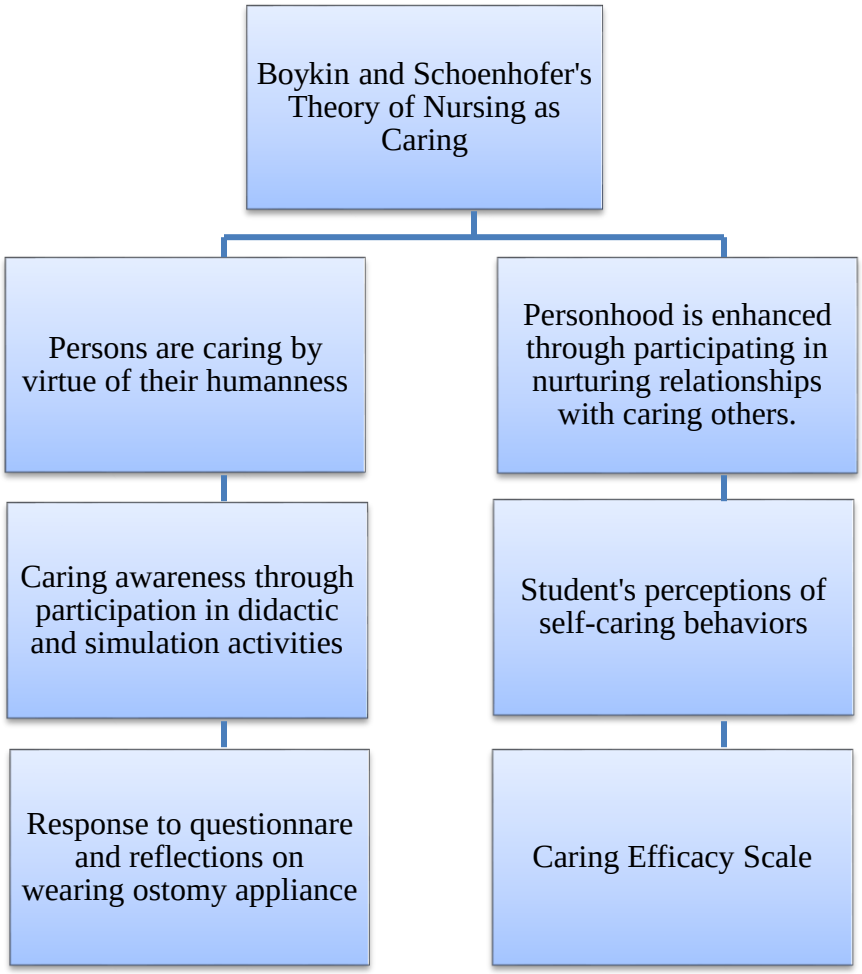

Figure 2. CTE Diagram Relating Boykin and Schoenhofer's Theory to Capstone Project.

Concepts and Definitions

Caring

The philosophy of caring science is not new, and has been studied and developed over decades. Milton Mayeroff (1971) a noted philosopher published an article on caring in 1965 and later wrote a book exploring the meaning and importance of caring.

Leininger's Cultural Care Theory of Diversity and Universality (1988) and Jean Watson's Theory of Transpersonal Caring (1979) were developed in the 1970's, and these scholars and many others continue to develop caring theories to focus on the importance of caring science in healthcare (Boykin & Schoenhofer, 2001; Leininger, 1988; Locsin, 2005; Swanson, 1993; Watson, 2008). When technology is used to know persons continuously in the moment, the process of nursing is lived (Locsin, 2005). The American Nurses Association (ANA), 2010 believes caring is central to the practice of the registered nurse. Under the characteristics of nursing practice tenants, the third item states: "Caring is central to the practice of the registered nurse" (ANA, 2010).

Although caring theories have been predominantly developed through nursing theorists, Watson and Browning (2012) believe theory-guided, evidence-based practices which move from superficial meanings of theory and human caring to authentic practices will certainly sustain the art of caring and transform those in a variety of healthcare fields. The major premise of Boykin and Schoenhofer (2001) rests on the belief all persons are caring, thus caring is an essential nature and expression of each human being throughout his or her life. The continued development, expansion, and application of caring theories demonstrate the key role that caring behaviors play in clinical practice (Diener & Hobbs, 2012).

Interprofessional Caring and Technology

Interprofessional education (IPE) is a collaborative approach to develop healthcare students as future inter-professional team members and improve patient outcomes (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011). Through inter-professional simulation training experiences Bridges et al. (2011) saw improvement in

communication, leadership, and the ability to gain insight into one's own profession and understanding of others. Students trained using IPE approaches are more likely to show respect, positive attitudes, and care about each other (Bridges et al., 2011).

Forming caring relationships or enacting caring presence may or may not be developed between students and simulated patients (Diener & Hobbs, 2012). The charge to educators in academic or institutional settings is to promote a caring curriculum using technology wisely and appropriately (Diener & Hobbs, 2012). Thus not only through simulated environments, but also in live engagements with patients the cultivation of caring behaviors needs to be modeled by healthcare educators (Diener & Hobbs, 2012). In the earliest stages of healthcare education, technology should not replace time spent in understanding the importance of developing a transpersonal relationship. The role of healthcare providers has changed along with technology, and although many are able to keep pace with these changes, technology challenges the caring relationship between patient and the provider (Korhonen et al., 2015).

SECTION IV

Project Design

The purpose of this project was to determine if a student's level of perceived caring and faculty assessment of student caring increased after incorporation of caring competencies and rotation through didactic lectures and two simulation-based learning experiences and debriefing. The following chapter presents the design, setting, sample, methods, ethical considerations to protect human subjects, surveys, data collection procedure, and data analysis used in this project.

Setting

This project was conducted at the College of Health Science in a private, liberal arts, faith-based university located in the Piedmont region of Western North Carolina. The university was established in 1905 as a high school, grew to a junior college in 1928, and was officially designated as a university in 1993.

The College of Health Sciences houses, the School of Nursing, the Physician Assistant Studies Program, Athletic Training Program, and the Exercise Science Program. The School of Nursing offers six programs of study including an ADN, traditional BSN, RN to BSN, Masters of Science in Nursing (MSN), Family Nurse Practitioner (FNP), and Doctorate of Nursing Practice (DNP), with an enrollment of approximately 700 students. The ADN, BSN, RN to BSN, MSN, and DNP programs are fully accredited by ACEN. The ADN and traditional BSN programs are offered in a traditional face-to-face classroom setting, the RN to BSN and MSN programs are offered online, and the FNP and DNP offers courses in a hybrid format.

The College of Health Science offers six simulation labs equipped with one high fidelity and five medium fidelity simulators, two nursing skills labs with 16 low fidelity simulators, eight exam rooms, wet lab, athletic training lab, exercise science lab, walking track lab, and anatomy lab equipped with Anatomage 3D tables for use in programs of study. Various debriefing or conference rooms are located throughout the building along with ample classroom space.

Sample

A convenience sample of 32 first-year ADN students enrolled in a fundamentals nursing course and experiential laboratory course were recruited as potential participants in this project.

Outcome Measurements

Before implementing the caring content into the course and simulation lab, students were asked to complete the Caring Efficacy Scale (CES) for baseline data and a brief demographic survey to describe the sample population (see Appendix B-C). The CES was created by Dr. Carolie Coates to assess an individual's confidence in his or her ability to express a caring orientation and establish a caring relationship with patients. The CES is a 30 item questionnaire based on a 6-point Likert scale (-3 = strongly disagree to +3 = strongly agree). The CES has a face validity and a reported Cronbach alpha of .88. Permission was obtained to use the CES. Pre and Post CES forms were analyzed for changes in aggregate means.

Later in the semester, as part of the ostomy appliance simulation, students were given an ostomy appliance reflection questionnaire created by the researcher to measure qualitative feedback from the student's experiences. This questionnaire is based on a

study by Diaz et al. (2015). The reflections were read by the researcher, analyzed for similarities and trends conveyed by the students after this assignment, and used for qualitative data. All submissions were anonymous and collected by the course instructor in a sealed envelope before being delivered to the researcher. Case study responses were also read to assess the reflections of students and considered along with students' comments during the debriefing sessions after the end-of-life simulation.

Procedure

Orientation to NURS 106

Students were given an explanation of the DNP project along with the informed consent form (see Appendix D). Students who agreed to participate in filling out the survey completed the Caring Efficacy Scale (CES) including brief demographics (see Appendix B - C). The pre-CES was printed on green paper to distinguish from the post-CES given at the end of the semester. All CES forms were collected at the end of class by the course instructor after the researcher had left in order to maintain confidentiality. Demographic forms were collected separately from the CES and placed in a different envelope by the course instructor before delivering both forms to the researcher. Students not wishing to participate turned in uncompleted surveys.

Lecture #1 caring science. Provided an introduction to the DNP project and caring science and caring theorists (see Appendix E).

Lecture #2 behaviors. Provided information on caring behaviors and caring competencies (see Appendix F) and caring construct handout (see Appendix G).

Death and dying lecture. Provided by the course instructor, with input as needed along with the following assignments:

1. Case Study assignment about caring (online module assignment, see Appendix H).
2. End-of-life simulation during labs (see Appendix I).

Lecture #3 Empathy and interpersonal interactions. Provided information on empathy, the elements of interpersonal caring, exploration or personal commitments and the identification with patients through wearing an ostomy appliance (see Appendix J).

1. Ostomy appliance simulation (see Appendix K).
2. Ostomy appliance reflection questions (48hr after wearing ostomy appliance, see Appendix L).

Conclusion of project. Delivery of the CES post-test one week after ostomy appliance simulation (see Appendix B) along with a debriefing statement distributed to the student upon completion of the CES (Appendix M).

In order to implement the Caring Competencies capstone project in the ADN Fundamentals NURS 106 (didactic) and NURS 107 (lab), all participants in this course were introduced to the capstone project and the initial concepts of Caring Science in August as the course began. All materials in lectures, case study (Module 4), end-of-life simulation, completion of pre and post Caring Efficacy Scale (CES), wearing of an ostomy appliance, and ostomy appliance questionnaire were incorporated into the required NURS106/107 courses and will remain a portion of these courses in the future. No identifying information was allowed on forms and in order to distinguish pre and post CES forms, pre-test forms were printed on light green paper, and post on white paper. All

forms were collected in large envelopes after class by the course instructor and later delivered to the researcher in order to maintain anonymity of all participants.

Each of the 15-20 minute lecture portions was woven throughout the curriculum: Initially as an introduction to caring science, during patient teaching to focus on communication, including care for the patient and family members during death and dying along with end-of-life and post-mortem care, and finally empathy and assistance with patients during major health issues and body image changes during colostomy care. The plan is for these segments to remain as new caring competencies and portions of NURS 106 and NURS 107 lab.

SECTION V

Evaluation Plan

To evaluate the effectiveness of the project, pre and post Caring Efficacy Scale (CES) provided aggregate means for comparing student perceptions caring efficacy before and after this course. Differences were analyzed using a t test.

The case study (Module 4) covered caring between a nurse and a young adult experiencing cancer. After reading the case study, students responded to study process questions to identify ways in which caring was demonstrated. Anonymous responses from the case study questions were to the qualitative data by comparing and looking for common themes in the students responses.

The end-of-life simulation was the first simulation encounter for students, and included a thorough pre-brief to assist students in how simulations are conducted, objectives, and what is expected during a simulation. After the simulation, a de-brief covered the simulation experience and discussed further the experience of dealing with death and dying, post mortem care, and caring interactions with patients and family members, as well as students' own personal feelings about the experience and possible future experiences.

The ostomy appliance simulation was a take home experience for students to wear an ostomy appliance for up to 48 hours in an anatomically correct location and then answer four questions in a reflection format created for this scenario. Reflection statements were collected anonymously and delivered to the researcher by the course instructor in a sealed envelope. All reflections were analyzed for common themes or traits

regarding feelings of empathy and caring towards patients with altered physical functioning. This information provided qualitative data for the DNP project.

SECTION VI

Project Implementation

The project was implemented as planned without changes or adjustments to the schedule or content. Interaction with the students and faculty involved in the NURS 106 course and NURS 107 labs were interactive and positive throughout the semester. The end-of-life simulation content was emotional and yet students expressed appreciation for the experience and debriefing conversations. Although not all students participating in the ostomy simulation submitted the reflection questionnaire, the majority expressed that this experience was definitely one they would recommend for future students.

Facilitators

In order to implement the project, the two course instructors for NURS 106 were consulted along with the pre-licensure chair. Coordinating the timing of the three mini-lectures, case study, and two simulation encounters was coordinated with the course chair to make sure that implementation of the project did not take away from already existing materials in NURS 106. Time was also spent with students and the lab instructors, whose efforts were also considered in making room for the caring presentations and implementation of the end-of-life and ostomy appliance simulations.

Objectives

The purpose of this study was to incorporate caring competencies into the academic curriculum(s) of the College of Health Sciences (CoHS) at University. The focus of this project was to start with the ADN Fundamentals of Nursing course (NURS 106) at the School of Nursing, and advance caring competencies throughout the nursing curriculum and eventually throughout all of the programs at the CoHS. The positive

response from both faculty and students in NURS 106 sets a great foundation for continuing to incorporate caring competencies throughout the curriculum.

The second objective, to increase the focus and importance of caring concepts and behaviors through didactic, simulation, and modeling, was met and surpassed as seen in the results of both the quantitative and qualitative data. Students consistently expressed a need for and learned new insights into caring science and the need for empathy and compassion in the healthcare fields.

The final objective, to add or reword caring competencies throughout the curriculum, and thus preserve the passion of these students as they enter the professional arena, may not be realized until these students have completed their academic studies and enter their professional careers. However, adding to and rewording caring competencies throughout the curriculum has gained new importance and will continue to be emphasized in each course and simulation experience.

SECTION VII

Results

Quantitative Data

Of the 39 students participating, all students completed the pre CES and 37 (95%) students completed the post CES. The expected return rate for surveys delivered face to face has been established as 80-85% (Instructional Assessment Resources, 2011).

The Caring Efficacy Scale (CES) was a 30 question Likert scale (1 = strongly disagree to 6 = strongly agree) rating self-perception of caring abilities. Pre-CES scores ranged from a low rating of 3.6 to high self-rating of six while post-CES scores ranged from a low of 4.3 to high of six. The results showed an increase in student's self-assessment of caring abilities after the completion of the project. The question rating the lowest score both pre and post CES was "I often find it hard to get my point of view across to patients/clients when I need to". The average score for this question was 4.5 before the caring education was implemented and 4.8 following the caring education. A paired samples *t* test was conducted to determine differences in pre and post-CES aggregate means. The mean for the pre CES (*M = 5.16*) was slightly less than the mean for the post CES (*M = 5.39*). The paired samples *t* test ($t(30) = -8.06$, $p < 3.46$), indicated no significant difference between the pre and post CES aggregate means (see Table 1). The slight increase in caring efficacy at the end of the semester may reveal a new conscious awareness of caring competencies in first year nursing students.

Table 1

Paired Two Sample t test for Means

	Variable 1 (Pre CES)	Variable 2 (Post CES)
Mean	5.155744797	5.389523833
Variance	0.057721459	0.041068716
Observations (questions)	30	30
Hypothesized Mean Difference	0	
Df	29	
t Stat	-8.058370133	
P(T<=t) two-tail	6.91397E-09	

Qualitative Data

An on-line caring case study module, "Caring between a nurse and a young adult experiencing cancer" (Dorsey, 2015) provided valuable qualitative data. This case study used multiple ways of knowing (personal, empirical, ethical, sociopolitical, spiritual, unknowing, emancipatory and aesthetic) to assist students in identifying the ways in which the nurse was able to care for and know the patient. Students identified the caring behaviors between the nurse and the patient. In addition, students shared how this study enhanced their knowledge of caring and how they might have handled the situation differently. The majority of students did not feel they would have done much more than the nurse in the story who exhibited a caring and patient attitude. The nurse spent extra time with the patient while attending to things like a foot massage and intentional listening while the patient shared her story. A few students mentioned they would have asked the patient about any spiritual support the patient may want. Many students indicated the case study made them realize that "sometimes the things one might consider as minor and incidental often make the greatest difference to patients".

Participation in the ostomy simulation provided students with an opportunity to experience empathy on a firsthand basis. Students participating in the experience were asked to wear the appliance for 48 hours, yet the ostomy appliance was worn anywhere from 6-50 hours. The most common responses on the impact on body image while wearing the ostomy appliance, was a feeling of humiliation, embarrassment, awkward, and very self-conscious. One student commented, "it made me feel like less of a human being." Emotions and feelings, while wearing the appliance, included feeling nervousness, depressed, violated, frustrated, uncomfortable, insecure, sad, and difficult to carry on activities of daily living. Wearing the ostomy affected relationships by making things awkward and embarrassing. Many felt they did not want to do the normal things they did with others while wearing the appliance. Overwhelmingly, students responded that wearing the ostomy appliance might help in relating to and caring for patients in the future by increasing empathy and growing understanding for the dramatic challenges a patient may experience.

Nineteen nursing students completed the Ostomy Appliance Reflection Questions for the Ostomy Appliance Simulation. Some of the responses to the questionnaire were as follows:

1. The impact on my body image was:
    - Made me very aware of the ostomy and I wanted to make sure it was hidden and secure.
    - Huge! It made me feel less like a human being.
    - Humiliating. I went on a date with my boyfriend (of 3 years) and I was embarrassed to go out in the public eye.

- I felt like everyone was staring at me.
- I constantly felt self-conscious that it was very noticeable. I was afraid to let anything touch it and felt like people could hear the bag crunch.

2. Emotions and feelings which I felt while wearing the ostomy appliance were:
    - It made me feel like I was dirty and needed to clean myself up.
    - Always wondering if people could see my bulge. I kept feeling the bag would burst, so I always watched what I did.
    - My number one emotion was “omg” people can see the outline of the bag through my clothes. I almost started to tear up because people actually have to go around with all these fears and worrying about people judging their bag.
    - I felt fear of what others would think if they noticed it. I experienced self-esteem issues, and depression that this was my body. It was broken and I was different.
    - I felt as though I was different than everyone else. I had to worry more about small things, such as the seatbelt pressing down too hard or laying the wrong way which made me self-conscious.
3. Wearing the ostomy appliance affected my relationships in the following ways:
    - Others understood, but felt like they couldn’t touch me.

- Many friends asked about it, and knew it was a “simulation”, but I am sure someone with an actual ostomy bag would have trouble explaining it to people who knew nothing about the appliance.
- It made me not want to hang out with friends because if I did, I would not be in a good mood.
- It affected my relationship with my boyfriend in a negative and positive way. Negative, as I was embarrassed to let him hold or cuddle me. Positive in his empathy for me wearing it made him extra sweet!
- My husband didn’t think about it, but I would get angry with him when he put his arm around my waist because he was pulling on it. I really didn’t want him to touch me while I had it on.

4. How will wearing the ostomy appliance help you relate in a caring way towards patients in the future?
    - It helped me understand from a patient’s point of view and made me realize that I can help patients when caring for them and make them feel important.
    - I really feel more empathetic. My grandfather had an ileostomy and it gave me a glimpse of what he felt and endured.
    - It will humble me as I now have experienced some of the emotional processed patients go through, and realize my experience was minimal in comparison to a real life scenario.

- The ostomy caused some skin irritation and although I can't completely understand how my patient feels, I believe I will be more sensitive when doing personal care because I realize how emotionally taxing not having the option of going without it can be.
- I will be more compassionate about it and will make a point to reassure patients that I understand how they feel and am there to assist them and help them.
- I can relate to my patients with a better understanding for how they are feeling, what challenges or struggles they are experiencing with an ostomy or other health related issues affecting self-confidence.

SECTION VIII

Discussion and Interpretation of Analysis of Findings

Findings and the Literature

Results from this project are similar to those of Blum et al. (2010) and Sokola (2013), indicating first year students show the desire and ability to care, but may not have the clinical competence to build trust in the nurse-patient relationship. This supports the need to weave caring competencies throughout the curriculum to assist in sustaining the development of professional caring behaviors.

The quantitative data of the CES showed only a slight increase in caring self-awareness and self-assessment, however, the qualitative data throughout showed a strong desire and increased awareness of the importance of caring competencies. Several students asked if this project would follow them through their didactic training, and many students consistently expressed these experiences helped them see aspects of caring they may not have realized. Some literature suggested that caring efficacy would be higher in the beginning of the semester and take a dip toward the end, however, quantitative data showed a slight increase in this project. Students in the ADN Fundamentals of Nursing course are generally varied in age and life experiences compared to BSN students, and this may have influenced the outcome to a certain degree. By having many of the caring components throughout the course, rather than during one lecture may have also added to the influence and importance of increasing caring awareness and implementation of caring behaviors. Students consistently engaged in conversation and discussions during lecture and debriefing of simulation activities conveying positive desire and appreciation of learning caring competencies.

Findings and the Theoretical Framework

The major assumptions of Nursing as Caring (Boykin & Schoenhofer, 2001) included the belief that all persons are caring by virtue of their humanness. The initial CES results indicated a middle to high self-estimation of caring by Fundamental students entering their academic nursing education. Interactions with students throughout the course often revealed deep introspection and evaluation of not only caring competencies, but the ability to grasp the concept of enhancing nurturing relationships and learning better ways of caring moment to moment. Affirmation of the simulation experiences to enhance caring communication and increasing empathy by wearing an ostomy appliance proved to be a valuable learning experience, which participating students felt all nursing students should have. The on-line case study also gave positive and insightful reflections by students. It was interesting to note that having the confidence to communicate caring was perhaps the greatest concern and need for students.

Process of Implementation

To better understand the implementation and incorporation of caring competencies in a nursing curriculum**,** faculty at Florida Atlantic University (FAU) were consulted via emails and a lengthy conference call. The Christine E. Lynn College of Nursing (CLCN) at FAU has a unique focus on caring which guides the philosophy and objectives of the nursing program. The CLCN (2016) definition of Caring Science states:

> Caring Science, in the discipline of nursing, is the body of knowledge arrived at through intentional research and theory development, focused on the relationship of caring to health, healing and well-being of the whole person within the context of the family, community, society and within the global environment.

The importance of caring science and the methods and history of the integration of caring competencies throughout the curriculum gave insight and depth to the importance of this project for the School of Nursing (SON) and all healthcare programs at the University. Talking with the faculty at FAU provided excitement for the longevity of this project and the encouragement and desire to look for opportunities to share the findings through conferences and publications.

After implementation of the project, discussions with the faculty involved resulted in the future incorporation of caring in NUR 106 would have one lecture in the course focused on caring competencies, revised end-of-life simulation into stations, keep the caring case study, and the ostomy simulation. According to the faculty involved, interjecting short lectures throughout the course was not always cohesive alongside other didactic material. However, keeping caring competencies and objectives in front of the students throughout all courses rather than in one lecture of one course may highlight the importance of caring and fully integrate caring into professional behaviors.

Faculty graciously allowed for participation, schedule rearrangements, and project personnel presence during didactic and lab settings, which enabled the execution of the project. Having the faculty present allowed for their participation and awareness of caring competencies and feedback from faculty provided positive information to the project. The end-of-life simulation may not be the best simulation for students learning fundamental skills, due to the lack of previous simulation experience and the heavy emotional content. It was discussed with the NURS 106 faculty and pre-licensure chair that a rotation through stations for end-of-life and post mortem care may provide a better learning experience for these students and still promote caring components as one station would

focus on communication with a grieving family member. The end-of-life simulation may be added to a more advanced course as part of caring competencies in the curriculum.

Mentoring relationships developed with students encountered throughout the project in the formal classroom or lab settings were some of the greatest rewards. Using Boykin and Schoenhofer (2001) major assumptions of Nursing as Caring highlighted the initial passion of beginning nursing students, noting caring as a human virtue. Didactic and casual conversations and interactions with students throughout the semester provided opportunities to mentor and talk about caring moment to moment. Mentoring relationships with students and taking the time to stop and help them with personal or academic problems gave meaning to caring science and a life grounded in caring. By participating in nurturing relationships with caring, students were able to see how this enhanced their professional and private lives. This project amplified the implementation of caring competencies and reinforced the desire for some students to strive to live a life grounded in caring science.

The value of adding caring science and caring competencies has been established with some faculty and will continue to be mentored and emphasized with all faculty to fully integrate caring competencies throughout the curricula. Due to time restrictions and the often overwhelming amount of material needed to instill in students during the educational hours for student engagement, some faculty may feel that other items continue to remain more important. Caring may often be demonstrated or talked about, however unless it is emphasized and added throughout the curriculum, it may be swept under the load of didactic content. Maintaining caring components and incorporating caring objectives throughout the curriculum in didactic and simulation experiences along

with findings of this project, needs to be discussed with the faculty of the SON and the College of Health Sciences to find the most appropriate ways to fully incorporate caring competencies.

The identity of healthcare professionals and specifically nurses often relates to the ability to care. This project provided evidence based research into the value of caring science which only fuels the passion for incorporating caring into the academic setting. There is substantial evidence and support for the need of a lifelong pursuit of creating caring healthcare professionals.

SECTION IX

Recommendations and Limitations

Recommendations and Dissemination of Findings

Recommendations to the programs within College of Health Science, is to further investigate and incorporate caring competencies and objectives throughout the curriculum. The results of this study will be shared with the School of Nursing (SON), the Physician Assistant Studies Program (PASP), and the Athletic Training and Exercise Science programs. Invitations to speak and share about incorporating caring competencies in the academic setting have been sought out and secured. Plans for publication of this project are also underway in an effort to share with others the value and importance of the focus and teaching of caring in the educational setting of all healthcare programs. In addition, meetings with various Deans, department chairs, and individual faculty will be arranged to encourage the incorporation of caring objectives and competencies throughout the curriculum.

Sustainability

The goal of this project was to fully integrate caring competencies throughout the curriculums of all programs within the College of Health Sciences. In order to begin with the School of Nursing (SON), discussions with the pre-license chair, faculty, Assistant Dean, and Dean will take place to pursue the best possible methods to instill at least one caring objective for each course. The material delivered in the Fundamentals of Nursing Course may be condensed into one didactic lecture, one on-line case study, and the two simulation activities during lab. Various simulation encounters with students are used throughout the SON and the College of Health Science, thus one caring objective can be

added to instill the need for caring behaviors and competencies throughout the curriculum. Future endeavors will focus on the Physician Assistant Program, through didactic and simulation activities.

The faculty of the SON have since added the following caring aspects to the Strategic Plan and changed wording to the philosophy to add caring aspects: "The *nurse*, as an independent provider of nursing care and part of the healing environment, uses science and the caring arts to nurture and promote human wholeness" (Gardner-Webb University, 2016). During the SON strategic planning meeting, faculty discussed ways the SON can also meet the University's priority goal of Christian Faith, Learning, and Social Responsibility. Emphasizing caring in the curriculum and in the Student Learning Outcomes for the program along with increased engagement with the community were part of this priority plan. One consideration included organizing a Day of Caring with non-curricular or curricular activities with students.

Creating caring protocols within an already crowded curriculum may seem overwhelming; however, the advantages far outweigh the difficulties of this task. Weaving caring competences throughout the curriculum may be the best strategy for classroom and online course formats. Hsu et al. (2015) conducted a three year study to implement and evaluate the effectiveness of a caring curriculum in two hospitals in Taiwan. The results showed a higher frequency of caring in the intervention group over the comparison group ($p < 0.001$). The curriculum was evaluated by caring providers and caring recipients. The most effective teaching strategies to enhance caring behaviors in the online course were: authentic experiences, reflective practice, and authentic experiences embedded in online videos. This study showed caring behaviors can be

cultivated by using reflective practice, authentic nurse and patient experiences as teaching materials, and online and audiovisual technologies.

Hold, Blake, and Ward (2015) studied the perceptions and experiences of nursing students enrolled in a palliative and end-of-life nursing elective through a qualitative study. The purpose of this study was to examine the experiences and perceptions of nursing students enrolled in a palliative and end-of-life nursing elective while integrating knowledge acquisition, practical experience and ethical identity. A purposeful sample of 19 students participated in focus groups to elicit which experiences were most helpful to student learning. Hold et al. (2015) revealed three main themes: learning from stories, learning from being there, and learning from caring.

Project findings were similar to Hold et al. (2015) in that caring competencies and the role of caring can often be difficult to assess; however, having faculty to guide and assist students through this process, and allowing for self-reflection may promote the acquisition of ethical knowing. Interpersonal bonds with patients and families were reflected in the students' journaling about experiences. This project, as with Hold et al. (2015) shows the importance of knowledge acquisition, practical experience, and ethical character which are key in helping students acquire a professional identity. This supports the importance of threading caring science into the curriculum throughout nursing programs or creating innovative courses to embrace a caring curriculum.

Limitations and Barriers

Limitations of this project include the small number of participants and limited time frame to assess the development and sustainability of caring competency development. In addition this project was limited to one course in one program, with a

convenience sample of students enrolled in the Fundamentals of Nursing course. Additional limitations include the limited number of hours for didactic and simulated encounters, which is already filled with content. These limitations may be overcome with faculty training and acceptance of the values and importance of caring science and caring competencies throughout the curriculum.

Barriers encountered during the implementation of this project centered on the need to clearly articulate caring competencies throughout all programs. A caring objective for the course was not added into the syllabus nor set out as an overall objective for NURS 106, and thus may have hindered the importance to both faculty and students alike. Change to any program creates resistance, with perhaps the two most common reasons being lack of time and organizational culture (Wallis, 2012). Getting past the common phrase “That’s the way we’ve always done it” may be one of the hardest barriers to overcome, thus faculty education about the importance of implementing caring competencies is vital.

SECTION X

Implications for Practice

A caring curriculum is integral to nursing education and, as a doctorally prepared nurse educator, the recognition and implementation of curricular designs to enable students to internalize caring behaviors is critical (Brown, 2011). Literature supports the internalization of affective learning through structured learning objectives, and the movement from emotional to reflective responses through critical reflection (Brown, 2011). Mastery of caring behavior occurs over time, and as educators, the modeling and teaching of caring competencies is vital to the implementation of caring behaviors in students and professionals. There is a need to transition the nursing curriculum from a major emphasis on skill development and content knowledge to one emphasizing caring and humanitarianism as core values (Brown, 2011). Understanding concepts such as cultural diversity, ethics, communications, and interpersonal relationships which are threaded into the curriculum from a caring perspective may allow students to reflect on their value system and respond sensitively to others (Brown, 2011).

Nurse educators need to be aware that students come into the academic setting with various backgrounds and may or may not have the ability to deal with some of the stressors of nursing school or the nursing profession. Students engaging in transformative learning environments and learning communities may face an increase in stress as they come face-to-face with their personal issues when using reflective practices (Clark, 2013). Nurse educators therefore need to be creative innovators of caring science to support future nurses and create caring-healing sustainable practices (Clark, 2013). One of the benefits of creating and teaching in a caring science curriculum is the opportunity

for the educator to also grow in his or her capabilities and walk alongside students in their journey of caring.

Over 36 years ago a group of doctoral nursing students gathered for the first conference to present research and philosophical reflections related to caring and nursing (Turkel & Watson, 2014). This group has continued to meet and grow to become an international collaboration and partnership. The International Association for Human Caring (IAHC) and the Watson Caring Science Institute (WCSI) are two organizations created with the intentional advancement of implementing caring science worldwide. Both the IAHC and WCSI work internationally to promote human caring, transcend borders, cultures, and religion (Turkel & Watson, 2014).

Lee, Palmieri, and Watson (2017) describes human caring literacy from the perspective of caring scientists incorporating the principles of human caring into their professional and private lives. In addition, the role of Caring Science Theory informs the lives of clinicians, nursing deans and faculty, and administrators in the United States and world-wide about the methods of providing authentic, heart-centered care for patients, their families, and societies (Lee et al., 2017).

Contribution of Project in Achieving DNP Essentials

A thorough evidence-based literature review along with caring theory foundations provided the scientific underpinning of this project for practice in the healthcare field and especially in the field of nursing education. Supplying the example and leadership of implementing caring competencies in the academic setting through simulation, lecture, an online case study, and modeling caring behaviors both with students and faculty this project provided evidence for quality improvement in the educational setting for the

School of Nursing (SON). The use of evidence-based simulations, facilitated debriefings, and written reflections advocated for the use of technology to improve and transform health care through caring modalities. The main goal of this project was to promote new health care policies and educational strategies in caring.

Research evidence supports a link between rationing of nursing care and negative patient outcomes such as increased mortality, patient falls, low quality of care, pressure ulcers, and hospital acquired infections (Papastavrpi, Andreou, Tsangari, & Merkouris, 2014). The issue within the patient safety movement suggesting that "acts of omission" are identified as one of the major types of errors not addressed in the literature (Papastavrpi et al., 2014). When caring competencies are not incorporated as a part of holistic care, acts of omission may occur.

Throughout the College of Health Science the creation of interprofessional opportunities has been established, thus adding to these opportunities and adding caring components will allow for improving patient and population health outcomes through caring teamwork. Rhodes, Morris, and Lazenby (2011) identified caring as a motivation for students to be competent in promoting positive outcomes for patients. They also noted that caring increases competence, ensuring nurses and healthcare teams to properly assess patients and perform skills. This will impact the dedication of all health teams to provide holistic care, improve population health, and improve the nation's health. Adding to the caring components and capacities of not only nursing, but all healthcare professionals will advance the nursing profession alongside those of other caring providers.

Nursing education plays an important role in the ability of students to practice effectively as professionals. Teaching caring science and caring competencies throughout

the nursing curriculum promotes teaching excellence in nursing education (Sawatzky, Enns, Ashcroft, Davis, & Harder 2009). Nurse educators need to remember caring transcends every aspect of nursing, including teaching, and reaching out to healthcare initiatives around the world.

Summary

Caring is a core value commonly associated with nursing practice. Research shows that when nurses exhibit caring behaviors to patients, then patient satisfaction with inpatient experience increases (Papastavrpi et al., 2014). However, exposure to the nursing education process often reduces the capacity for expressive care (Murphy et al., 2008). The nursing educational process should promote and support the student to preserve the positive perspectives they arrive with and enhance the ability to care for their patients and themselves. Brown (2011) identifies a gap in knowledge about how nursing curricula can help internalize caring behaviors in students. Caring in nursing and nursing care is not the same. Caring in nursing is the intentional extension of the self to another through intrapersonal and interpersonal experiences (Brown, 2011). Care for the whole person is often fragmented, and some question if care and compassion are still at the heart of the nursing profession (Wood, 2014). Evidence indicates the great need for changes in nursing curricula to incorporate caring science and caring protocols.

The National League for Nursing (NLN) challenged educators to model affective behaviors that demonstrate caring equally as visible as the cognitive and psychomotor components of nursing education (Brown, 2011). The NLN suggested strategies to enhance nursing students' internalization of caring behaviors such as carative factors and affective competencies which may assist to promote caring behaviors and competency (NLN, 2015). Student recruitment may include interview questions relating to the

capacity and desire to care along with perceptions of what nurses really do in the workforce (Wood, 2014). Regardless, nurse educators have the responsibility to prepare new graduates with the competencies necessary to provide safe, competent and ethical nursing care (Sawatzky et al., 2009). Clark (2013) believes there is an ethical obligation to revise and re-vision current nursing educational practices and in order to produce and promote caring-healing sustainable practices in nursing professionals, thus nurse educators should create innovative caring-science curricular changes.

Although caring is a desirable attribute in nursing students and in nursing professionals the educational process seems to reduce caring behaviors (Murphy et al., 2008). In order to provide teaching excellence in nursing education, the incorporation of a caring framework is essential, as it is to every aspect of nursing. Sawatzky et al. (2009) designed the Caring Framework for Excellence in Nursing Education to guide novice educators, establish the basis for evaluating excellence in nursing education, and provide the stimulus for further research. Because caring is not necessarily innate to nurses, it needs to be clearly articulated, modeled, taught, and learned to fully encompass caring behaviors. The importance of a teaching philosophy entwined in a caring framework provides the framework for teaching excellence. Caring within teaching leadership is reflected in the ability to motivate and empower others by integrating caring into the curriculum and may provide novice faulty with a basis for evaluating excellence in nursing education through caring components (Sawatzky et al., 2009).

There is a growing concern world-wide to improve the implementation and development of caring in the nursing profession (Phillips et al., 2015). A caring protocol may positively affect patient care because it provides the nurse with a practice standard

which fosters patient and family centered care (Wolf et al., 2014). In order to become advocates in the healthcare system, students need to understand the complex organizational culture and the dichotomy between caring and economics (Maykut & McKendrick-Calder, 2013). The choice of healthcare service settings is connected to patient satisfaction and perceived caring treatment environments often associated with nursing services and nursing attributes of caring (Wolf et al., 2014). By implementing caring standards of practice early in an academic program, students may find a balance between clinical competence and the value and practice of holistic patient caring.

This project is a beginning attempt to integrate caring science and measure caring literacy within the School of Nursing (SON) and eventually the College of Health Science (CoHS). Interprofessional approaches in healthcare education result in students who are more likely to show respect, positive attitudes, and care about each other, thus forming caring teams. The Interprofessional Education Collaborative (2011) identified desired principles for interprofessional competencies and team based care which include relationship focused collaborative cooperation to deliver patient-centered care. In order to accomplish this, each course will need to be evaluated to see which caring competencies can be highlighted and incorporated. By adding one caring objective per course and simulation events, the importance of caring elements can be maintained throughout the curriculum and become a vital part of caring competencies for all healthcare professionals.

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Appendix A

Mission, Values, Philosophy, and Goals

Gardner-Webb University

Mission

Gardner-Webb University, a private, Christian, Baptist-related university, provides outstanding undergraduate and graduate education that is strongly grounded in the liberal arts while offering opportunities to prepare for various professions. Fostering meaningful intellectual thought, critical analysis, and spiritual challenge within a diverse community of learning, Gardner-Webb is dedicated to higher education that integrates scholarship with Christian life. By embracing faith and intellectual freedom, balancing conviction with compassion, and inspiring a love of learning, service and leadership, Gardner-Webb prepares its graduates to make significant contributions for God and humanity in an ever-changing global community.

Values

Christian Heritage: Acknowledging One God - Creator and Sustainer of life, and Jesus Christ as Savior and Lord; committing to self-giving service displayed in Christ-like moral action that respects the dignity and value of every person.

Baptist Heritage: Affirming historic Baptist values such as the freedom of individual conscience and the right of people to worship God as they choose, the authority of Scripture in matters of faith and practice, the priesthood of every believer, the autonomy of the local church, and the separation of church and state.

Academic Excellence: Encouraging visible enthusiasm for knowledge, intellectual challenge, continuous learning, and scholarly endeavors; inviting pursuit of educational opportunities within and beyond the classroom for the joy of discovery; and inspiring accomplishment within one's field of study.

Liberal Arts: Offering broad-based exposure to the arts, humanities and sciences and to each field's unique challenges, contributions, and life lessons; complementing the acquisition of career-related knowledge and skills with well-rounded knowledge of self, others, and society.

Teamwork: Working collaboratively to support and promote shared goals, assuming responsibility willingly, meeting commitments dependably, handling disagreement constructively, and persevering despite distraction and adversity.

Student-Centered Focus: Providing students an environment that fosters intellectual and spiritual growth; encourages physical fitness, service, social and cultural enrichment;

strengthens and develops moral character; and respects the value and individuality of every student.

Community Engagement: Assisting campus, local, national, and global communities through education, outreach, and research; fostering dialogue and action in support of human welfare and environmental stewardship.

Diversity: Studying and celebrating our world's rich mix of cultures, ideologies, and ethnicities; respecting and welcoming students without regard to ethnicity, gender, religious commitment, national origin, or disability.

Hunt School of Nursing

Mission:

The mission of the Hunt School of Nursing is to enhance the health status of the global community by preparing individuals to practice holistic and professional nursing through the provision of student centered programs of study for a diverse student population that promotes academic excellence within a Christian, private, liberal arts setting utilizing teamwork and community engagement

Philosophy:

The faculty of the School of Nursing functions within the framework of the purpose and value statements of Gardner-Webb University which focus on providing high quality education within Christian, private, liberal arts setting. The School of Nursing philosophy represents a framework of overarching beliefs of the nursing faculty that lays the foundation for individual program philosophy, goals, and organizing concepts. The philosophy of the School of Nursing consists of basic beliefs regarding expected outcomes of nursing education at all levels. The nurse is an independent provider of nursing care, a manager of nursing care and a member of the interdisciplinary team. Health is the person’s previous, current, and future state of mental, physical, emotional, and spiritual functioning. Environment encompasses all previous, current, and future phenomena that impact the well-being of the person. The faculty is committed to providing nursing education that is consistent with best practice and that builds upon previous knowledge. The following competencies for nursing practice are derived from current professional standards and utilized as the basis of nursing education at Gardner-Webb University.

Goals:

1. Establish liberal arts educational environment based on Christian values fostering academic excellence, integrity, and a commitment to lifelong learning.
2. Provide student-centered programs of study based on current national competencies of nursing practice to meet the global health care needs of individuals, groups and communities in which holistic nursing practice, Christian caring, critical thinking, and professionalism are modeled.

3. Engage in partnerships with community health care facilities in the provision of service learning opportunities for students that include patient-centered care, evidence-based practice, and interdisciplinary collaboration.
4. Graduate a diverse population of students who are prepared to practice patient-centered nursing care that is culturally competent, holistic and professional within the context of a global environment in a manner that influences nursing and health care policy and practice.

Physician Assistant School

Mission: Develop knowledgeable and caring Physician Assistants who practice competent patient-centered primary care in diverse environments.

Goals:

Knowledge – Cultivate high quality graduates committed to self-discovery and self-assessment and committed to the application of critical thinking and analysis of research.

We strive to achieve Physician Assistant National Certifying Exam (PANCE) pass rates compatible with the national average and ideally will achieve and maintain a 100% pass rate. Our first class will graduate in May 2016 to take the PANCE.

We develop student clinical reasoning skills through intensive team and problem based learning discussions and activities to provide competent patient centered care and demonstrate self-directed and lifelong learning. The curriculum follows an organ based systems approach with students participating in skills sessions, cases studies, and literature searches for problem solving. Clinical rotations provide a wide range of primary care clinical experiences.

Faith – Foster a commitment to Christian values, ethics, and integrity in personal and professional service as a physician assistant.

In keeping with our faith based program, we encourage students to provide compassionate and ethical care that is reflected in their attitude and approach to patient scenarios and interactions. We cultivate a collaborative learning environment for students with one another via team based activities and with faculty having an open door policy and dedicated time for student mentoring.

Service – Emphasize a servant-leadership lifestyle, which prepares graduates to serve in underserved communities, domestically and abroad.

Students are encouraged to serve in primary care for diverse populations and for the underserved. All of our students are required to complete a clinical rotation in a medically underserved area or for a medically underserved population. Our first student cohort initiated and conducted health screenings for the homeless at a local church. We are developing international mission opportunities for rotations and we foster a

relationship with local organizations that can provide opportunities for personal mission trips.

Leadership – Develop a solid professional value system, committed to life-long learning, professional development, and advocacy for the profession.

Professionalism is emphasized as a component of academics. Students elect their government representatives who participate in faculty meetings and have membership opportunities in national and state PA organizations. Our faculty participates annually in the Physician Assistant Education Association (PAEA) conferences and workshops to remain well-informed to educate and encourage our students to play an active role in addressing the issues facing our profession. The PA program is housed in the Gardner-Webb University College of Health Sciences building that is shared with the Nursing and Preventative and Rehabilitative Health Science departments providing additional opportunities to reinforce inter-professionalism.

School of Preventive and Rehabilitative Health Sciences

Mission:

The mission of the School of Preventive and Rehabilitative Health Sciences (PRHS) is to integrate the knowledge, skills, and values of the health sciences that contribute to the prevention of disease and disability and maintenance and restoration of health and function. We deliver student-centered education that is accentuated by evidence-based teaching in the cognitive (knowledge), psychomotor (skills), and affective (abilities) learning domains, within a Christ-centered environment that emphasizes faith, service, leadership, and a commitment to life-long learning. We focus on the prevention and management of disease and disability through the promotion of healthy behaviors and lifestyles, effective assessment, and early intervention through the use of evidence-based exercise prescription, treatment, and rehabilitation to restore health and function. Although united by a common mission, each of the interrelated academic programs (Athletic Training, Exercise Science) has its own distinct body of knowledge, skills, and abilities to achieve the following goals:

Goals:

1. Provide undergraduate curricula based on current best practices in each discipline;
2. Provide basic instruction and discipline-specific courses that support attainment of knowledge, skills, and abilities that prepare competent and contributing entry-level professionals;
3. Provide for constant review and assessment of curricula to ensure academic quality and consistency, with an emphasis on discipline specific current best practices; and
4. Provide professional service to undergraduate students, the University community, allied health groups, organizations and practitioners.

(Gardner-Webb University, 2016)

Appendix B

Caring Efficacy Scale©

Instructions: When you are completing these items, think of your recent work with patients/clients in clinical setting. Circle the number that best expresses your opinion.

Rating Scale:	-3	strongly disagree	+1	slightly agree
	-2	moderately disagree	+2	moderately agree
	-1	slightly disagree	+3	strongly agree

		Strongly Disagree					Strongly Agree
1.	I do not feel confident in my ability to express a sense of caring to my clients/patients	-3	-2	-1	+1	+2	+3
2.	If I am not relating well to a client/ patient, I try to analyze what I can do to reach him / her	-3	-2	-1	+1	+2	+3
3.	I feel comfortable in touching my clients/ patients in the course of care-giving	-3	-2	-1	+1	+2	+3
4.	I convey a sense of personal strength to my clients/ patients	-3	-2	-1	+1	+2	+3
5.	Clients/ patients can tell me most anything and I won't be shocked.	-3	-2	-1	+1	+2	+3
6.	I have an ability to introduce a sense of normalcy in stressful conditions.	-3	-2	-1	+1	+2	+3
7.	It is easy for me to consider the multifacets of a client's / patient's care, at the same time as I am listening to them.	-3	-2	-1	+1	+2	+3
8.	I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client/ patient as a person.	-3	-2	-1	+1	+2	+3
9.	I can walk into a room with a presence of serenity and energy that makes clients / patients feel better.	-3	-2	-1	+1	+2	+3
10.	I am able to tune into a particular client/patient and forget my personal concerns.	-3	-2	-1	+1	+2	+3
11.	I can usually create some way to relate to most any client/ patient.	-3	-2	-1	+1	+2	+3
12.	I lack confidence in my ability to talk to clients / patients from backgrounds different from my own.	-3	-2	-1	+1	+2	+3
13.	I feel if I talk to clients/ patients on an individual, personal basis, thing might get out of control.	-3	-2	-1	+1	+2	+3
14.	I use what I learn in conversations with clients/ patients to provide more individualized care.	-3	-2	-1	+1	+2	+3

15.	I don't feel strong enough to listen to the fears and concerns of my clients/ patients.	-3	-2	-1	+1	+2	+3

Caring Efficacy Scale©

		Strongly Disagree					Strongly Agree
16.	Even when I'm feeling self-confident about most things, I still seem to be unable to relate to clients/ patients.	-3	-2	-1	+1	+2	+3
17.	I seem to have trouble relating to clients/ patients.	-3	-2	-1	+1	+2	+3
18.	I can usually establish a close relationship with my clients/ patients.	-3	-2	-1	+1	+2	+3
19.	I can usually get patients/ clients to like me.	-3	-2	-1	+1	+2	+3
20.	I often find it hard to get my point of view across to patients/ clients when I need to.	-3	-2	-1	+1	+2	+3
21.	When trying to resolve a conflict with a client/ patient, I usually make it worse.	-3	-2	-1	+1	+2	+3
22.	If I think a client/ patient is uneasy or may need some help, I approach that person.	-3	-2	-1	+1	+2	+3
23.	If I find it hard to relate to a client/ patient, I'll stop trying to work with that person.	-3	-2	-1	+1	+2	+3
24.	I often find it hard to relate to clients/ patients from a different culture than mine.	-3	-2	-1	+1	+2	+3
25.	I have helped many clients/ patients through my ability to develop close, meaningful relationships.	-3	-2	-1	+1	+2	+3
26.	I often find it difficult to express empathy with clients/ patients.	-3	-2	-1	+1	+2	+3
27.	I often become overwhelmed by the nature of the problems clients/ patients are experiencing.	-3	-2	-1	+1	+2	+3
28.	When a client/ patient is having difficulty communicating with me, I am able to adjust to his/her level.	-3	-2	-1	+1	+2	+3
29.	Even when I really try, I can't get through to difficult clients/ patients.	-3	-2	-1	+1	+2	+3
30.	I don't use creative or unusual ways to express caring to my clients/ patients.	-3	-2	-1	+1	+2	+3

Appendix C

Incorporating Caring Competencies

Demographic Form

Age: (Please list your current age) ____

Gender: (Please circle one of the following)

Male

Female

Years of healthcare experience: ____

Previous degrees: Yes____ No ___

Note: Demographic information is only to describe the general population of the students.

Appendix D

Informed Consent Form

You are being asked to participate in a research study conducted by Rebecca C. Threatt, a Doctor of Nursing Practice student at Gardner-Webb University (GWU).
PURPOSE: The purpose of this study is to determine the comfort, familiarity and knowledge level of student nurses in regards to caring, caring science and caring competencies.

PROCEDURE: You are being asked to complete a demographic form, the Caring Efficacy Scale (CES), and ostomy appliance reflection questionnaire. Once you have completed these surveys, you will have no further obligations to the study. The researcher will provide instructions on how to complete the surveys.

VOLUNTARY PARTICIPATION: Participation in this study is voluntary. Your decision to participate or not to participate will in no way affect your involvement in the Associate Nursing Degree program or your employment. You have the right to refuse to answer any question(s) for any reason without penalty.

CONFIDENTIALITY: The researcher is asking you to complete all surveys anonymously. Please do not disclose any identifying information on the survey. All research data will be stored in the researcher's home in a locked file cabinet. All electronic data will be stored on the researcher's personal computer which is password protected. After completion of the study, all surveys will be given to the Hunt School of Nursing for storage. Surveys will be kept for three years in a secured location.

RISKS & BENEFITS: The Institutional Review Board at GWU has determined that participation in this study poses minimal risk to participants. There are no direct benefits associated with participation in this study.

If you have questions, want more information or have suggestions, please contact Rebecca C. Threatt, who may be reached at 704-406-2514 or at rthreatt@gardner-webb.edu.

If you have any concerns about your rights, how you are being treated, or complaints regarding this study, benefits, or risks associated with being in this study please contact the Institutional Review Board of GWU at 704-406-4724.

CONSENT TO PARTICPATE:
Please retain this copy of the consent form for your records.

By completing the surveys you are voluntarily consenting to participate in this research study. If you choose not to participate in this study, please discard this survey.

Appendix E

Introduction to Caring Science Lecture #1

Outline

1. Introduction to Caring Science
    a. Philosophy and Vision of Caring Science
    b. Relationship of caring competencies to self-care, family systems, nurse education and workplace culture
    c. Caring for self, colleagues, and patients
2. Caring Theorists
    a. Madeleine Leininger
    b. Roach
    c. Jean Watson
    d. Boykin and Schoenhofer
        i. Major assumptions underlying Nursing as Caring Boykin & Schoenhofer (2001) include:
            1. Persons are caring by virtue of their humanness
            2. Persons are caring, moment to moment
            3. Persons are whole or complete in the moment
            4. Personhood is a process of living grounded in caring
            5. Personhood is enhanced through participating in nurturing relationships with caring others
            6. Nursing is both a discipline and a profession

Objectives

1. Discuss the impact of the philosophy and vision of the nursing department on caring activities in the organization.
2. Discuss caring behaviors with fellow classmates: what caring looks like, feels like, and share with each other and in class discussion.
3. Compare selected nursing theorists and their influence on clinical practice.

Reference

Boykin, A. & Schoenhofer, S. O. (2001). *Nursing as caring: A model for transforming practice.* Sudbury, MA. Jones and Barlett.

Wolf, Z. R., Bailey, D. N., & Keeley, P. A. (2014). Creation of a caring protocol: Activities and dissemination strategies in caring research and instruments. *International Journal for Human Caring, 18*(1). 66-82.

Appendix F

Caring Science Lecture #2

Outline

1. Caring Behaviors
    a. Nurse investment in safety is a caring activity/behavior
    b. Nurse caring and clinical competence
2. Perceptions of caring, caring activities/behaviors
    a. Caring constructs
        i. Respectful
        ii. Connectedness
        iii. Knowledge and Skill
        iv. Assurance
        v. Attentiveness
        vi. Collaboration
3. Influence of consumerism
    a. Consumerism
    b. Consumer power and rights
    c. Satisfaction with nursing care; outcomes of nursing services

Objectives

4. Examine the connection between caring activities and patient safety strategies.
5. Describe caring perceptions, caring constructs, and caring activities.
6. Examine the influence of consumerism on patients' and family members' expectations from healthcare services and providers.

Reference

Boykin, A. & Schoenhofer, S. O. (2001). *Nursing as caring: A model for transforming practice.* Sudbury, MA. Jones and Barlett.

Wolf, Z. R., Bailey, D. N., & Keeley, P. A. (2014). Creation of a caring protocol: Activities and dissemination strategies in caring research and instruments. *International Journal for Human Caring, 18*(1). 66-82.

Appendix G

Caring Constructs

1. **Respectful:** courteous regard for the other (comforts; established and maintains a helping/trusting relationship; respects individuality).

   Nursing Activities (actions, behaviors):

   - Intends to enhance patient's welfare/situation by caring about, for and with him/her.
   - Acts courteously and deferentially
   - Introduces self and identifies title
   - Maintains professional boundaries with patient and family
   - Calls patient by his/her preferred name
   - Acts in genuine manner to create a therapeutic relationship with patient
   - Positions body and used nonverbal indicators of connection to demonstrate a focus on patient and family
   - Explains specific roles of members of the healthcare team
   - Reviews visitation policy with patient and family
   - Explains physical space of unit to patient and family, including location of bathroom
   - Respects patient's dignity
   - Keeps patient information confidential
   - Provides privacy for patient and family wherever care is provided
   - Protect patient's rights
   - Established trusting relationship with patient and family
   - Shows concern for patient and about patient's situation
   - Expresses concern regarding patient's injury, illness, or situation
   - Explains nurse's role in his/her care that day to patient
   - Involves patient and family in care
   - Supports patient's independent decisions
   - Sustains eye contact during interaction with patient and family consistent with cultural practices
   - Listens patiently to patient and family
   - Is empathetic with patient and family
   - Is gentle
   - Accepts patient's silence
   - Demonstrates no biases
   - Is honest with patient and family and provides honest answers
   - Gives feedback to patient and family
   - Follows up and follows through with patient and family as promised
   - Keeps relatives informed about a patient consistent with patient's wishes
   - Respects patient's expressed wishes regarding end-of-life care

2. **Knowledge and Skill:** nurse caring as proficient, informed, and skillful (explains and facilitates; monitors and follows through; teaches and evaluates learning; assists with human needs; is competent practitioner; coordinates care; provides emotional support; provides physical comfort; involves patient/family; creates healing environment for physical and spiritual self; assists with physical, emotional, and spiritual human needs).

   Nursing Activities (actions, behaviors):

   - Creates a healing physical environment for patient and family, including noise control, sufficient light and warmth, odor control, art, and comfort
   - Meets patient's physical needs
   - Measures patient's vital signs
   - Monitors patient's status
   - Assists patient and family with ADLs (bathing, toileting, dressing, transferring, walking)
   - Acts promptly to decrease patient's discomfort, distressing symptoms, and suffering
   - Checks on and documents patient's pain, fatigue, distress, and anxiety
   - Evaluates patient's sleep patterns
   - Responds in timely manner to indicators of patient deterioration
   - Performs comprehensive assessment of needs and concerns from patient's frame of reference
   - Provides food and beverages as needed and allowed
   - Demonstrates professional competence with clinical procedures
   - Gives patient treatments and medications on time
   - Observes and evaluates effects of medication on patient within 30 to 60 minutes of medication administration
   - Demonstrates proficiency with interpersonal skills
   - Provides emotional support for patient and family
   - Responds to, reassures, empathizes with, and consoles patient and family
   - Supports patient and family through dying and grieving processes
   - Communicates realistic and liberal time expectations for various states in process of care
   - Teaches patient and family by explaining procedures, treatments, treatment alternatives, medication, and rationales for interventions
   - Reviews medication side effects
   - Explains details of every intervention and procedure to patient and family before procedure begins
   - Encourages patient to perform self-care
   - Instructs patient and family about aspects of self-care
   - Helps patient to mobilize necessary resources

3. **Connectedness: optimistic and constant readiness on part of nurse to help the other** (operates from perspectives of humanism/faith-hope-sensitivity; instills

faith and hope; accepts positive/negative expressions; provides emotional support; is open to extraordinary events).

Nursing Activities (actions, behaviors):

- Uses handshake or touch on arm in acceptable manner to patient
- Is available/accessible to patient and family
- Engages in patient's and family's situation
- Promotes patient's self-esteem
- Is hopeful and cheerful with patient
- Is truthful and realistic about patient's situation
- Reassures patient and family about clinical procedure
- Asks patient if he/she has any needs
- Encourages patient and family to ask questions
- Asks patient and family if questions are answered clearly and needs were met
- Encourages patient to express feelings about his/her disease and treatment
- Encourages patient to express his/her feelings, beliefs, concerns, and positive and negative feelings.

4. **Assurance: investment in other's needs and security** (is supportive/protective/corrective; maintains safe physical environment).

   Nursing Activities (actions, behaviors):

   - Watches over patient with vigilance
   - Conducts proactive, hourly rounds on patient
   - Checks on patient frequently without being called
   - Stays with patient during clinical procedure
   - Protects patient from injury
   - Safeguards patient safety by verifying patient identification, protecting from falls, administering medications correctly and checking on ordered medications, and preventing pressure ulcers, etc.
   - Promotes sense of protection and rest to patient and family
   - Checks that patient has functioning call light at all times
   - Responds immediately to call light
   - Is available to patient and family to focus on his/her concerns
   - Pays attention and responds to patient's cues
   - Attempts to calm patient's fears
   - Asks, "Is there someone you would like us to call for you?"
   - Responds to patient's and family's requests for follow up visits and questions
   - Provides information to the patient and family about how to contact healthcare providers for appointments and other concerns or problems

5. **Attentiveness: appreciation of and engrossment in the other's perspective and experience** (is accessible, anticipates patient's family's, caregiver's needs; considers existential/phenomenological dimensions; respects cultural and spiritual practices, beliefs, and needs).

   Nursing Activities (actions, behaviors):

   - Gets to know patient as a person
   - Learns patient's story, situation, and context
   - Seeks to discover patient's values, beliefs, and desires
   - Support patient's beliefs and values
   - Supports patient's spiritual, emotional, mental, physical, cultural, and social needs.
   - Acts sensitively with patient and family
   - Engages in patient's and family's experience
   - Pays attention to patient's healing
   - Anticipates patient's needs and concerns
   - Verifies patient's and family's understanding
   - Evaluates meaning of subjective and objective patient concerns
   - Acknowledges and responds to patient's description of priority needs and concerns
   - Explains that patient's condition may alter which priority needs and goals are met first
   - Advocates for patient in culturally sensitive manner
   - Supports patient's culturally-based practices
   - Pays attention to gender issues and sexual concerns
   - Sustains continuing caring relationship with patient and family

6. **Collaboration: engagement in collegial, interdependent partnership** (cooperative; interdisciplinary shared planning; open coordination and communication; shares decision making, problem solving, responsibility, and goal setting).

   Nursing Activities (actions, behaviors):

   - Creates and maintains community of caring among nursing staff, including nurse-to-nurse support
   - Extends community of caring to fellow nurses, patient, family, and other departments/services
   - Discusses with patient and family the contributions of different members of the healthcare team to patient's plan of care and implementation of care
   - Contributes to the community of caring among all healthcare providers so that the needs of patients and family dominate
   - Communicates with patient and family using strategies that match where he/she and they are

- Fosters collaboration among caregivers by communicating and planning with caregivers, patients, and family
- Conducts routine, interdisciplinary rounds with members of the healthcare team, patient, and family to foster ongoing communication
- Implements plans for direct communication with patient, family, other nurses, physicians, and healthcare team member to assure continuity of care
- Communicates effectively with patient, family, physicians, other nurses, and all services/departments in organization concerning patient and family.
- Communicates process of care and expected treatment to ream so patient, family, nurses, physicians, and other care providers know about tests, procedures, test results, etc., and changes in plan of care
- Communicates plan of care in writing and verbally to members of the interdisciplinary healthcare team
- Documents patient information in patient record
- Sits with patient for at least 5 minutes per shift to plan and review patient's plan of care
- Assists patient in decision-making and planning
- Alerts members of healthcare team to the need of nursing staff to know and be a part of details of end-of-life communications
- Supports decisions regarding patient's immediate and long-term future
- Co-creates a plan for comprehensive caring and healing that is coordinated with medical plan of care for patient and family
- Refers patient and family concerns and problems to members of the interdisciplinary healthcare team consistent with their expertise
- Explains rationale for referring patient's and family's concerns and problems to other members of the healthcare team
- Oversees comprehensive care planning
- Assures performance of comprehensive care planning
- Facilitates seamless care
- Follows through with prioritized plan of care

Reference

Wolf, Z. R., Bailey, D. N., & Keeley, P. A. (2014). Creation of a caring protocol: Activities and dissemination strategies in caring research and instruments. *International Journal for Human Caring*, *18*(1). 66-82.

Appendix H

NUR106/107 Online Module 4

Caring Between a Nurse and a Young Adult Experiencing Cancer

Directions: As you prepare to intentionally enter the world of the other, reflect on the following question as you read: What are the expressions of caring between nurse and the one nursed?

The Queen and her family

Mrs. Quinn, a person I cared for before my ICU days, has never left my heart. She was a 30-year-old woman hospitalized in a step down unit. Immediately I pegged her for an easy admit and discharge. The other nurses avoided her room, and I figured it was because she was ornery and staff was not able to deal with her. I was assigned to her because I was the only one that did not refuse. Armed with this false sense of who she was and half expecting a demanding rude patient, I started my shift and opened her door. I was taken aback by how beautiful she was. She was a fit, young woman from the Caribbean, with gorgeous tan skin and a little black pixie haircut. Her sweet young children, a boy and a girl, were lying beside her. Her husband was at her bedside, despondent with his head in her lap as she stroked his hair. She looked like a queen consoling her king. Her big doe eyes met mine, and if I could say there were a moment God Almighty Himself put me right where I needed to be, it was at that moment. She had stage four uterine cancer with metastasis to the lungs and bone. I couldn't wrap my mind around how somebody who looked better than I did physically could be so sick. I proceeded to care for her, took her vital signs, and offered her medication as ordered. When asked how she was feeling, she barely spoke to me.

When her family left the following morning, her stoic guard collapsed. She waited until her husband and children left before she let her true feelings show. She told me her story, how quickly she was diagnosed, and stated, "As a woman and mother, I have to be strong for them. Do you mind if I cry with you?" It was time for my shift to end, and I ended up spending three hours after my shift just talking to her, listening, consoling, and being present in the moment. She said I reminded her of her sister. She explained how she accepted God's challenge but lived in the real fear of leaving her family behind. There was a solid strength in her that awed me and as we spoke like two old friends, I felt Godly agape love. Her realness with me was baffling. I could see she bottled up all these emotions for the sake of her family and I was happy to be her shoulder to cry on. She told me something that will resonate with me forever: "I may not ever know for sure why I was put on this earth, but I sure hope that I left the people I loved in life in a better state than I found them. I won't question God, because His will is sovereign over anything, but I'm a human. I'm scared and I'm not ashamed of that."

I washed her hair and massaged her feet before I left, and we shared a final hug. I was so devastated that something so bad was happening to somebody so nice that I admit that I questioned Almighty God as to why these terrible diagnoses plague people. I understand why colleagues refused her as a patient now. It physically hurt me to take care of her, because I cared about her so much. The essence of caring in this nursing situation is courage.

Study Process Questions

1. What was the caring between the nurse and the one nursed, how was it demonstrated?

2. Using the Ways of Knowing, how can we come to understand the call(s) for nursing? (See Table 1 below and answer at least one of the questions under each category.)

   Personal Knowing:

   Empirical Knowing:

   Ethical Knowing:

   Sociopolitical Knowing:

   Spiritual Knowing:

   Unknowing:

   Emancipatory Knowing:

   Aesthetic Knowing:

3. What are the calls for nursing? (The nurse identifies the call for authentic presence and to listen to her hopes and fears. What other calls may be present? What mattered most to Mrs. Quinn at this moment in time? What might be "unspoken" calls? What are the calls from her family?)

4. How did the study of this nursing situation enhance your knowledge of nursing? (What did I learn about myself as I studied this situation? What did I learn about caring science? What new possibilities can be created from this nursing situation?)

5. What are your thoughts on caring expressed by the nurse in this situation? What would you have done differently and why?

Table 1

Personal Knowing: Who am I as a caring person? Who is Mrs. Quinn as a caring person? What personal knowing do I bring to this situation? What do I know about caring for a person with terminal cancer? What are my own spiritual belief related to health, illness and death?

Empirical Knowing: What knowledge is needed to care for a person with Stage 4 cancer? What knowledge of death and dying is needed to care for Mrs. Quinn? What are the evidence-based practices for pain management? In addition to foot massage, what complementary modalities could be helpful in caring for Mrs. Quinn? What knowledge is needed to care for Mrs. Quinn's family? What therapeutic communication techniques would be beneficial to enhancing the well-being of Mrs. Quinn?

Ethical Knowing: What ethical principles are present in this nursing situation? How do the codes of ethics guide practice? How did the nurse fulfill professional obligations to Mrs. Quinn? How would advance directives influence nursing care for Mrs. Quinn?

Sociopolitical Knowing: How do Mrs. Quinn's cultural beliefs impact her health and well-being? How does Mrs. Quinn's role as a wife and mother influence her understanding in decision making? What is the meaning of stoicism for Mrs. Quinn and

her family? What knowledge is needed to understand how Mrs. Quinn's financial status may influence end-of-life care?

Spiritual Knowing: How should I support Mrs. Quinn's religious and/or spiritual beliefs and practices?

Unknowing: What mattered most to Mrs. Quinn at this moment in time? What do we know about Mrs. Quinn from her husband and children? How could the nurse remain open to understanding Mrs. Quinn, her family, and colleagues?

Emancipatory Knowing: How could the nurse advocate for Mrs. Quinn in this nursing situation? How do the laws related to citizenship and immigration impact health care? What barriers to Mrs. Quinn's care are present?

Aesthetic Knowing: What was the beauty of nursing in this nursing situation? How could this nursing situation be re-presented aesthetically?

Reference

Dorsey, M. (2015). Caring between a nurse and a young adult experiencing cancer. In Barry, C. D., Gordon, S. C. & King, B. M. (Eds.) *Nursing Case Studies in Caring* (pp. 105-110). NY, Springer.

Appendix I

NURS 106/107

Simulation: End-of-Life

Faculty Copy

Level: Basic

Topic: Basic End-of-life and Post Mortem Care

Skills: Pain assessment, vital signs, patient positioning, care of dying patient and family, post mortem body care.

Pre-brief:

1. Orient to simulation room, simulator, and equipment
2. Explain simulation assignment and divide into three groups
3. Explain participant and observer roles
4. Discuss student reactions to end-of-life
5. Explore how to communicate with family effectively
6. Questions and answers about simulation scenario

Overview:

Mr. Little is a 70 year old male who came with a diagnosis of lung cancer with metastasis to bone. He was receiving hospice care at home but his wife felt his care had become unmanageable due to his restlessness and dyspnea and called an ambulance to take him to the hospital where he was admitted for symptom management. He has no IV access due to poor circulation and is receiving morphine 15 mg SL q 4 hours PRN and Transderm-Scop 1.5 mg patch every 72 hours PRN for excess secretions. Foley catheter intact with dark amber urine (16 Fr). He is a DNR and has oxygen at 2 LPM via nasal cannula.

Objectives:

1. Perform assessment of critically ill patient
2. Enhance communication skills with patient's family
3. Explore strengths and weaknesses of student's caring responses

Elapsed Time (approx.)	Manikin Actions	Family or other Cues	Expected Interventions	Expected Outcome
5 mins.	• **Moaning** • **VS: P 98, RR 28/shallow, BP 108/60, O_2 sat 92%** • **Coarse, wet breath sounds**	**As instructor gives end of shift report.** **SP: Mrs. Little calls out that Mr. Little is very restless.**	✓ Receive report ✓ Wash hands ✓ Properly position patient, raise HOB, left up in bed, etc ✓ Notice patient is moaning and assess pain ✓ Take note of vital signs and monitor, no intervention is necessary right now ✓ Can ask for help lifting patient up in bed, properly lower side rail, etc ✓ Check MAR for medication for pain and administer following the five rights.	✓ O_2 sat=94% ✓ Continues to have wet breath sounds ✓ RR 28/shallow ✓ Mouth appears dry. ✓ Stops moaning.
10 mins.	• **Continues to have wet breath sounds with ineffective cough.** • **VS: P 98, RR 28/shallow, BP 108/60, O_2 sat 90%** • **Occasional episodes of apnea.**	**Mrs. Little: Can't you suction him? Why does he have so many secretions?** **Mrs. Little: His mouth seems so dry, why is that?**	✓ Explain to wife about excessive secretions in imminent death and that suctioning will increase these. ✓ Check MAR for medication for secretions and administer following the five rights. ✓ Provide oral care.	✓ O_2sat=94% ✓ Secretions lessen.

Switch Groups - Part B

Objectives:

1. Engage in withdrawal of care of critically ill patient
2. Enhance communication skills with patient's family
3. Explore strengths and weaknesses of student's caring responses

5 mins.	• **Apneic episodes become more frequent.** • **VS: P 48, RR 10/shallow with apneic episodes, BP 58/30, O_2 sat 82%**	**Mrs. Little: Is he dying? I'm not ready for him to die.** **Mrs. Little: Crying as pt. does not breathe at times.**	✓ Explain to wife that he will become more apneic and that death is near. ✓ Encourage wife to express feelings to patient. ✓	Wife is tearful.
10 mins.	• **Apneic episodes become more frequent.** • **Asystole all VS cease**	**Mrs. Little: Crying as realizes patient has died, responds appropriately to nurses telling her he has died.** **Mrs. Little: I think I need to call someone to take me home, but I want to come back in and say my last goodbyes.**	✓ Assess for cessation in respirations and apical pulse. ✓ Inform wife of patient's passing. ✓ Offer to call someone for wife.	Wishes to make some calls but wants to come back and see husband after care is given.

Switch Groups – Part C

Objectives:

1. Engage in pronouncement of death of patient
2. Enhance communication skills with patient's family
3. Explore strengths and weaknesses of student's caring responses

5 mins.	• **No vital signs or sounds.**	**Pronouncement of death, notification to nurse supervisor or provider. Nursing Supervisor calls to remind about LifeShare and body to morgue.**	✓ Calls Lifeshare to determine donor status**.** ✓ Prepare body by removing all tubes and prepare body for family to enter and have time for goodbyes.	
10 mins.	• **No vital signs or sounds.**	**Mrs. Little: crying and saying last goodbye to husband.**	✓ Allow wife to have time with patient before placing in body bag. ✓ Prepare body by removing all tubes and tagging body and placing in body bag.	Wife is tearful. Body is ready for morgue.

Debriefing:

1. What is the first thing that comes to mind about the clinical experience you just had?
2. Discuss student reactions to end-of-life
3. Explore communication with family, what was effective, why or why not?
4. What went right and why?
5. What would you do differently and why?
6. What is the client/patient's story?
    a. Any clinical issues?
    b. Nursing priorities?
7. Any other nursing interventions which could have been done? (rationale):

Reference

Lippe, M. L. & Becker, H. (2015). Improving attitudes and perceived competence in caring for dying patients: An end-of-life simulation. *Nursing Education Perspectives, 36*(6). 372-378.

NURS 106/107

Simulation: End-of-Life

Pre-simulation Preparation

Setup mannequin to have gray hair, male, plain abdomen with speaker hooked up. Set up wall unit with oxygen and place nasal cannula on mannequin. Foley catheter inserted with less than 75 cc dark amber urine. Have suction set up. Provide extra pillow, towels, washcloths, and post-mortem kit available but not at bedside. Have a chair for the wife at bedside. Pyxis will need to be stocked with Roxanol (morphine liquid) 20mg/mL and Transderm-Scop 1.5 mg patch. Chart should include MAR, nurse's notes, physician's order sheet, and DNR order. Provide a LifeShare organ donation form if available (at nurses' station).

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Simulation: End-of-Life

Student Report

Instructor should read this aloud to the group:

Mr. Little is a 70 year old male admitted with a diagnosis of lung cancer with metastasis to bone. He was receiving hospice care at home but his wife felt his care had become to unmanageable due to his restlessness and dyspnea and called an ambulance to take him to the hospital where he was admitted for symptom management. He is restless but only responsive to pain and moans. He has oxygen at 2 LPM via nasal cannula and his breath sounds are coarse rhonchi. His extremity pulses are weak and cool to touch. Blood pressure is low. He has no IV access due to poor circulation and is receiving morphine 15 mg SL q 4 hours PRN and Transderm-Scop 1.5 mg patch every 72 hours PRN for excess secretions. Foley catheter intact. He is a DNR and I don't think he will make it through your shift. The forms for the funeral home have already been done and were faxed over by hospice. LifeShare organ donation forms are at the nurses' station if needed. His wife is at his side.

Appendix J

Caring Science Lecture #3

Outline

1. Empathy
    a. Definition
    b. Importance in healthcare
2. Interpersonal interactions
    a. Intentionality and authenticity
    b. Impact of active listening and communication skill on nurse caring
    c. Space, body position and gaze
3. Introduction and instruction of ostomy appliance simulation and questionnaire

Objectives

7. Understand the definition of empathy and its importance in patient care.
8. Investigate elements of the interpersonal caring ritual.
9. Explore nursing's commitment to excellence in interpersonal relationships with patients.
10. Identify with patients through wearing of ostomy appliance.

Reference

Boykin, A. & Schoenhofer, S. O. (2001). *Nursing as caring: A model for transforming practice.* Sudbury, MA. Jones and Barlett.

Diaz, D. A., Maruca, A. T., Kuhnly, J. E., Jefferies, P., & Graon, N. (2015). Creating caring and empathic nurses: A simulated ostomate. *Clinical Simulation in Nursing*, *11*(12). 513-518.

Appendix K

Ostomy Appliance Simulation

Objectives

1. Experience life changes similar to a patient with an ostomy appliance.
2. Gain insight into patients' feelings and struggles by wearing an ostomy appliance.

Goals

1. To enhance empathy and caring in nursing students by wearing an ostomy appliance.
2. Promote self-debriefing and insight into caring competencies through reflection questions. Reflection is the foundation of good debriefing and enhances learning (Dreifuerst, 2015).

Simulation

Students will be asked to wear an ostomy appliance filled with 30 ml of simulated content for 48 hours. The appliance will need to be worn in an anatomically correct location consistent with typical patients' care of an ostomy. After the 48 hour time period students will complete the ostomy appliance reflection questions (as seen on Appendix C). Students will be able to relate how many hours they wore the appliance and reflect upon the personal impact of wearing the appliance and how this may or may not change their ability to empathize and care for patients with ostomies in the future.

References

Diaz, D. A., Maruca, A. T., Kuhnly, J. E., Jefferies, P., & Graon, N. (2015). Creating caring and empathic nurses: A simulated ostomate. *Clinical Simulation in Nursing, 11*(12). 513-518.

Dreifuerst, K. T. (2015). Getting started with debriefing for meaningful learning. *Clinical Simulation in Nursing, 11*(5). 268-275.

Appendix L

Ostomy Appliance Reflection Questions

Please complete the following questions after wearing the ostomy appliance for 48hrs. (Please reflect as much as you can, using more than one word, and feel free to use additional space on the back of this page.)

hrs ostomy appliance actually worn: _____

1. The impact on my body image was:

2. Emotions and feelings which I felt while wearing the ostomy appliance were:

3. Wearing the ostomy appliance affected my relationships in the following ways:

4. How will wearing the ostomy appliance help you relate in a caring way towards patients in the future?

Reference

Diaz, D. A., Maruca, A. T., Kuhnly, J. E., Jefferies, P., & Graon, N. (2015). Creating caring and empathic nurses: A simulated ostomate. *Clinical Simulation in Nursing*, *11*(12). 513-518.

Appendix M

Incorporating Caring Competencies

Debriefing Statement

The study you have just completed was designed to identify caring behaviors and self-evaluation of caring, after participating in caring-based activities and lectures.

The importance of caring is a major part of the initial passion of most healthcare professionals. The desire to deliver quality care and the ability to provide care can be challenged by technology and workload demands and time constraints of healthcare students and professionals (Huston, 2013). Patient satisfaction is linked to a positive impression of care from professionals. Patient satisfaction is currently linked to reimbursement schemes, which is important to healthcare delivery and viability of institutions (Wolf, Bailey & Keeley, 2014). Incorporating caring protocols early in the academic setting and continuing to highlight them will encourage caring behaviors, relationship building, and clinical collaboration (Korhonen, Nordman & Eriksson, 2015).

Thank you for your participation! If you have any questions about the study, please feel free to contact Rebecca C. Threatt or Dr. Gayle Casterline at 704-406-2418. If you would like to obtain a copy of the group results of this study, please contact Rebecca C. Threatt at 704-406-2514 at the end of Spring, 2017.

Thank you so much!

References

Huston, C. (2013). The impact of emerging technology on nursing care: Warp speed ahead. *The Online Journal of Issues in Nursing*, *18*(2), Manuscript 1.

Korhonen, E., Nordman, T., & Eriksson, K. (2015). Technology and its ethics in nursing and caring journals: An integrative literature review. *Nursing Ethics*, *22*(5), 561-576, doi: 10.1177/09697333014549881

Wolf, Z. R., Bailey, D. N. & Keeley, P. A. (2014). Creating of a caring protocol: Activities and dissemination strategies in caring research and instruments. *International Journal for Human Caring*, *18*(1), 66 – 82.