



# Translating Caring Theory Into Practice

## *The Carolina Care Model*

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This article describes how one organization operationalized Swanson Caring Theory and changed practice to ensure consistently high standards of performance. The Carolina Care Model developed at the University of North Carolina Hospitals is designed to actualize caring theory, support practices that promote patient satisfaction, and transform cultural norms. Evaluation suggests that this approach to care delivery enhances patients' and families' hospital experience and facilitates desired outcomes. The authors outline the Professional Practice Model, key characteristics of Carolina Care, links to caring theory, and development and implementation methodologies.

A theory is an explanation, and it has been said that nothing is as practical as a good theory.<sup>1(p346)</sup> Yet there is a persistent gap between nursing theory and practice. The implications of theories are often not readily apparent to practicing nurses. As a result, theory-guided practice remains an ideal versus a reality in most organizations.

Swanson<sup>2,3</sup> Caring Theory may be a notable exception in accelerating progress toward this goal. As a middle-range theory inductively derived from nursing research, Swanson's structure of caring provides a coherent explanation of the links between caring processes and patient well-being. At a deeper level, the subdimensions of each process suggest ac-

tionable interventions that make the theory-practice connection intelligible and useful to clinicians.

Caring theory postulates that nurses demonstrating they care *about* patients is as important to patient well-being as caring *for* them through clinical activities such as preventing infection and administering medications.<sup>3,4</sup> Implementing the Carolina Care Model is one approach to actualizing caring theory across a healthcare organization by systematically incorporating interventions that link nursing actions, caring processes, and expectations.

### ***Caring Theory and Professional Practice***

The Professional Practice Model (PPM) for University of North Carolina Hospitals (UNCH) completed in 2008 is grounded in caring theory (Figure 1).<sup>3,4</sup> A meta-analysis of 130 nursing studies of caring conducted by Swanson<sup>3</sup> evaluating knowledge about caring in nursing resulted in 5 hierarchical levels:

1. Level I: Capacity for caring: Does the nurse have what it takes to be caring?
2. Level II: Concerns/commitments: Is the nurse committed to relating in a caring manner?
3. Level III: Conditions: Does the environment support capable, committed nurses to practice caring?
4. Level IV: Caring actions: Does practice consist of actions that are based on knowing, being with, doing for, enabling, and maintaining belief in patients?
5. Level V: Caring consequences: Does acting in a caring manner promote intended outcomes?<sup>5(p33)</sup>

There are parallels between these levels and the UNCH PPM are depicted in Figure 1. The PPM is a

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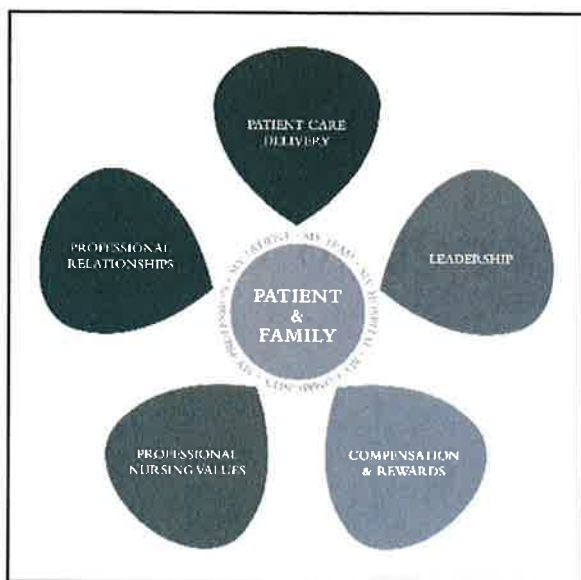


Figure 1. UNCH nursing PPM. Reprinted with permission.

systems approach to creating the conditions for caring. For example, highly structured behavioral interviewing in the leadership component is used to select new nurse employees who have the capacity to care.<sup>5</sup> The values in the center of the schematic make clear where the commitment of UNCH nurses lies: What matters most are my patient, my team, my hospital, my community, and my profession. These concerns clarify which relationships matter. The deliberate use of the word “my” validates the organizational norm and professional expectation for relationship-based nursing practice.<sup>5</sup>

Swanson identifies 3 types of conditions that affect caring: patient related, nurse related, and organization related. Organizational conditions for caring are encompassed in several components of the PPM, including the following:

- Leadership: staff-led shared governance councils and chief nursing officer (CNO) advocacy
- Compensation and rewards: professional development opportunities, clinical ladder, merit-based performance programs, and employee incentive plan
- Professional relationships: just culture and relationship-based caring in a healing environment

These components create a healthy work environment that supports capable, committed nurses practicing in caring.

Caring actions are demonstrated in patient care delivery at UNCH in the relationship-based care delivery model called Carolina Care. Nursing at UNCH is practiced in the context of a relationship-based care delivery system that focuses on 3 critical relationships

in quality healthcare: with the patient/family, with colleagues, and with self.<sup>6</sup> Carolina Care addresses the first of these, the nurse’s relationship with patients and families. Outcomes are assessed through continuous monitoring of key indicators including patient satisfaction and nurse-driven results. This discussion focuses on the fourth level of the caring hierarchy, caring actions embodied in the Carolina Care delivery model, and links between Carolina Care actions, Swanson Caring Theory, and related outcomes.

## Background

Caring theory provides the conceptual framework for the PPM developed at UNCH. In 2009, nurse leaders were faced with a need to improve patient satisfaction as measured by the Press Ganey (PG) survey patient experience scores. A model was developed that translated caring theory into specific caring behaviors and incorporated them in practice. Leaders of the development process sought to build a set of consistent behaviors that communicated caring to patients. The set of behaviors would be a demonstrative expression of caring grounded in the PPM and replicable by nurses in every practice setting. Translating caring theory into practice, the nurse would actualize the PPM for the benefit of each patient. The vision was for congruence between the PPM and caring behaviors to be so strong that it distinguished the care provided at UNCH.

## Care Delivery as Caring Actions

Swanson<sup>2,3</sup> Caring Theory is a middle-range theory developed and validated based on 3 studies in perinatal settings. Swanson<sup>3</sup> describes nursing as “informed caring for the well-being of others.”<sup>3(p352)</sup> She presents a structure of caring composed of 5 interrelated caring processes:

1. Maintaining belief—sustaining faith in the capacity of others to transition and have meaningful lives
2. Knowing—striving to understand events as they have meaning in the life of the other
3. Being with—being emotionally present to the other
4. Doing for—doing for the other what they would do for themselves if possible
5. Enabling—facilitating the capacity of others to care for themselves and family members<sup>3</sup>

As illustrated in Figure 2, these processes, grounded in a culture of maintaining belief, combine nursing compassion (knowing and being with) and competence (doing for and enabling), leading to the intended outcomes of patient healing and well-being.

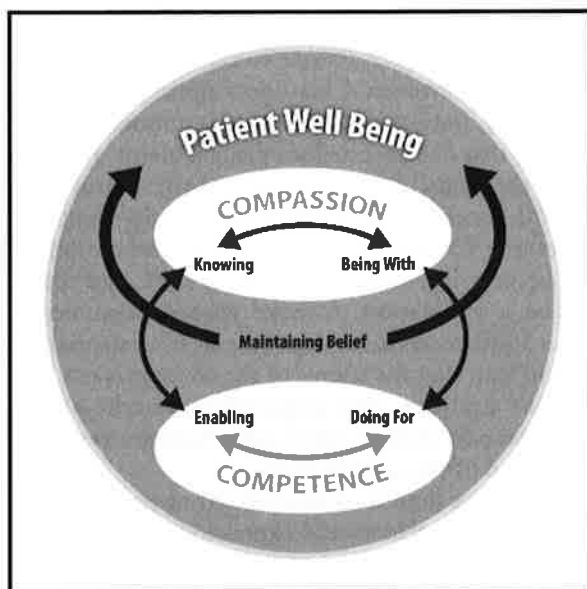


Figure 2. Swanson Caring Theory: Framing the Culture of Carolina Care. Printed with permission.

Carolina Care is a consistent set of behaviors that increase patient satisfaction in partnership with other support service departments essential to care delivery. The key behavioral characteristics of Carolina Care are as follows:

1. Multilevel rounding
2. Words and ways that work
3. Relationship/service components
4. Partnerships with support services

### Multilevel Rounding

Regular leader and staff rounds on patients positively affect patient satisfaction and perception of quality of care.<sup>7,8</sup> Carolina Care includes 5 levels of rounding. At the patient care level, staff nurses and nursing assistants round on alternate hours. The structure of rounds is summarized in the acronym ROUNDS as follows:

1. **R**—are you comfortable? (pain)
2. **O**—other side (positioning)
3. **U**—use the bathroom (toileting)
4. **N**—need anything?
5. **D**—door/curtain open or closed (privacy)
6. **S**—safety (call bell in reach, hazards removed)

Hourly rounds represent an alternative approach to organizing nurses' time and work. Patient needs are anticipated and met on a timely basis, resulting in a more satisfying experience for the patient and less use of call lights.<sup>8</sup>

Hourly rounds combine elements of the caring processes of *being with* and *doing for*.<sup>2,3</sup> Initiating interaction with the patient on a frequent, regular basis

conveys availability. The structure of the rounds enables the nurse to anticipate patients' needs and afford opportunities to provide comfort and protection.

Interviews with patients indicated that the health unit coordinator (HUC) was often perceived as a barrier to reaching their nurse. Health unit coordinator rounds were designed as a response to proactively address this concern. The HUC rounds to meet new patients to explain who they are and that they may be the voice most often heard responding to the call lights and offer reassurance regarding their desire to help patients in collaboration with the nurse.

Nurse managers round on patients to assess their condition and care. They round with staff on patients to observe staff interactions with patients. Management rounds are designed to quickly address patient concerns and to collect feedback to share with staff. Managers also round with members of the leadership teams of support service departments. Rounds provide managers from departments such as environmental services (EVS), food and nutrition (FNS), and plant engineering with direct feedback from patients about their services.

### Words and Ways That Work

Professional nurses may react negatively to the term "scripting," commonly used to describe the practice of directing staff to communicate verbatim messages to patients in an effort to improve satisfaction. A less prescriptive approach, "words and ways that work" suggests key points to cover in interaction that repeatedly occur (eg, meeting a patient for the first time). Staff are expected to individualize the conversation and communicate and/or solicit important pieces of information in their own words.

A number of these communications can be linked to *enabling*.<sup>2,3</sup> The purpose of such exchanges is to inform and explain situations to enable patients to be active participants in their care. Depending on the content of the communication, there may be links to other caring processes, such as *being with*, which is discussed in the context of partnering with support services.

### Relationship/Service Components

For this discussion, the most relevant components of Carolina Care include the following:

1. Moment of caring
2. No passing zone
3. Partnerships with support services
4. Blameless apology

### Moment of Caring

Patients indicated through the PG survey that they felt their emotional needs often were not always met or completely addressed during hospitalization. To

respond to this feedback, nurses are asked to spend a “moment of caring” with each patient each shift, sitting down with patients for 3 to 5 minutes to talk about how they are coping with their illness, while touching their hand or arm, as appropriate. It is unfortunate that this has to be planned, but in fast-paced hospital environments, competing responsibilities make it difficult for the nurse to find time to sit with patients. This practice helps nurses recognize that it is not only all right to spend this time with patients, but that it is expected. A moment such as this exemplifies *being with*, and information the patient shares may contribute to *knowing*.<sup>2,3</sup>

### No Passing Zone

“No passing zone” communicates to all members of the nursing staff that no one passes by a patient’s call light regardless of the specific assignment for patient care. Signs such as those on roadways designating “no passing” are posted in hallways to remind staff to respond to lights. This practice is designed to convey the availability of the entire staff to *do for* all patients on the unit.

### Partnerships With Support Services

In addition to ensuring that service standards are met (eg, food is delivered to patients at the correct temperature), partnerships with support service departments extend the use of words and ways that work to support service employees who have frequent contact with patients. As one example, EVS staff members are expected to initiate interaction with the patient in the room while cleaning by commenting on a personal item, such as a photograph or card. This suggests that the staff member is emotionally present or *being with* and gives patients another opportunity to talk about meaningful aspects of their lives.

### Blameless Apology

Blameless apology is indicated when some part of a patient’s hospital experience fails to meet expectations and results in a complaint. In these cases, staff members talk with the patient to gain a clear

understanding of what happened, offer a blameless apology, and initiate actions to correct the issue or prevent reoccurrence. A blameless apology acknowledges the patient’s concern; communicates an apology that does not include placing blame, regardless of the origin of the problem; and offers assurance that the concern will be addressed. Apologizing for something not within their scope of responsibility can be very frustrating for nursing staff, and there can be a temptation to make negative comments about another service or department. It is essential to remind staff that the source of the concern is not the patient’s problem, and disparaging remarks about any other part of the hospital contribute to a negative perception of the organization.

Spending time to actively listen to patients’ descriptions of problems and expressions of their feelings and concerns conveys presence and availability. Taking action to address concerns enables patients to feel a greater sense of control of their environment.

The links between caring processes and caring behaviors suggested in the preceding descriptions of Carolina Care interventions are summarized in Table 1. As previously indicated, these processes are grounded in a culture of *maintaining belief*.

### Development on Model Units

During project design, a hospital that had sustained PG scores in the 99th percentile nationally was consulted, and a number of best practices were tested, and adapted for an academic health center. These modifications were integrated with additional interventions, some original to UNCH, to create Carolina Care. Two acute care units were selected to develop Carolina Care. These units contained private and semiprivate rooms with typical PG scores. A steering committee, chaired by the CNO, was created to provide high-level direction, integration, and support. Both model units organized nursing and interdisciplinary teams. The nursing team consisted of nurses, nursing assistants, and HUCs. The interdisciplinary team included the nursing team and unit-level representatives from FNS,

**Table 1. Proposed Links Between Carolina Care and Swanson Caring Theory Processes**

		Swanson Caring Theory Processes			
		Knowing	Being With	Doing For	Enabling
Carolina Care interventions	Moment of caring	✓	✓		
	Hourly rounds		✓		
	No passing zone		✓	✓	
	Words and ways that work		✓		✓
	Blameless apology		✓		✓

EVS, and plant engineering. The nurse manager led both teams to develop action plans that would demonstrate caring behaviors and improve performance related to specific PG questions.

The first step was to ask patients what selected survey items meant to them and how staff could better demonstrate caring. Patient descriptions of caring behaviors served as the foundation for the development of Carolina Care. A rapid cycle process improvement approach was utilized for 6 months. Press Ganey survey data were monitored based on date of discharge rather than date received to provide a clearer relationship between process changes and results. Team members representing each department were assigned specific items for which they were accountable. They were responsible for development of an action plan to improve performance. The entire team had to approve the plan as a suitable course of action to achieve desired outcomes. If there was little or no improvement after a month, another approach was implemented until the right set of caring behaviors was identified and levels of service improved. The model units were successful in achieving a greater than 60 percentile improvement in key areas of meeting emotional needs, response to call lights, concerns, and complaints, and overall patient satisfaction.

### Implementing Across Acute Care

A Carolina Care guidebook was written by nurse managers and directors from the model units and distributed to all acute care managers. An implementation oversight committee similar to the unit-based model was organized including the CNO, directors of all nursing service lines, and the support services of FNS, EVS, and plant engineering. This committee

was cochaired by the directors of surgery services and public affairs and marketing. Carolina Care was implemented simultaneously across all 19 acute care units over a 10-week period.

The first phase consisted of prework for the manager. Two weeks were provided to form teams, conduct patient interviews, assess staff readiness, and analyze 1 year of patient satisfaction data. This prework also included tracking the frequency, time, and reason for call bell use. The aesthetics of each patient room from the patient's viewpoint were assessed. Upon completion of the prework, managers reviewed their findings with their director and team. Each manager was given a percentile ranking and/or mean score target for the unit's patient satisfaction goal.

Over 8 weeks, components of Carolina Care were introduced in succession. Every Monday, nurse managers met to review the components for that week and discuss the previous week's implementation. Unit interdisciplinary teams met biweekly to review progress and address challenges. Plant engineering relocated clinical items in direct patient view (eg, sharps containers) and replaced them with art.

Nurse managers received nominal funds to conduct the unit kickoff celebrations and achievement of milestones. Carolina Care Bucks, redeemable in hospital food venues, were provided for spontaneous recognition for staff demonstrating desired behaviors. Achievement awards were presented at hospital department head meetings to units reaching their patient satisfaction goals for 3 consecutive months.

### Results

Prior to the implementation of Carolina Care, the hospital PG mean scores had hovered for a number

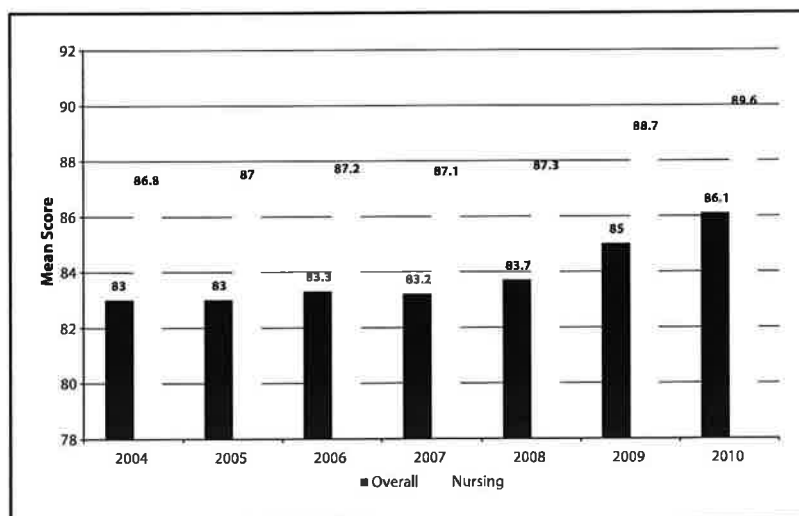


Figure 3. Annual UNCH patient experience metrics: mean score for overall satisfaction and satisfaction with nursing 2004-2010.

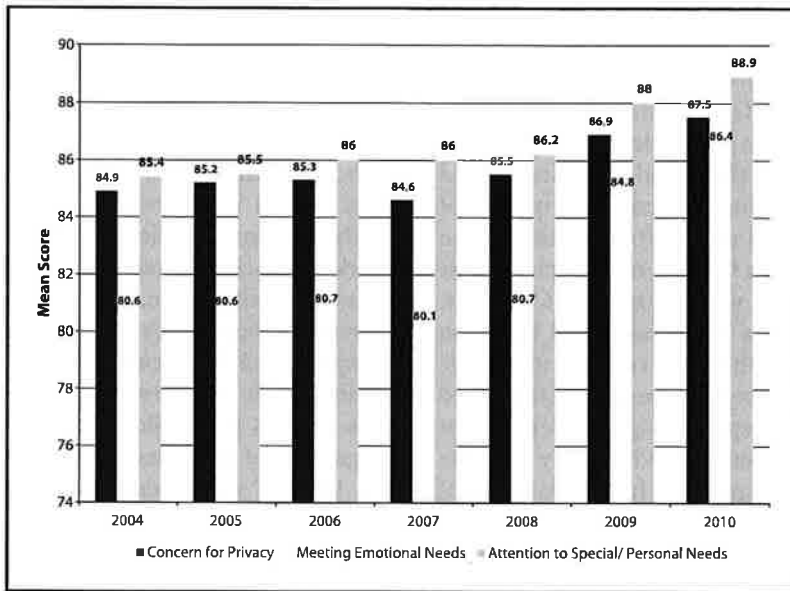


Figure 4. Annual UNCH patient experience metrics: mean score for satisfaction with concern for privacy, meeting emotional needs, and attention to special/personal needs.

of years around the same levels despite multiple efforts to improve. With the implementation of Carolina Care in 3rd quarter of 2009, the mean score for overall patient satisfaction began the first steady and sustained climb in 6 years. The organization quickly exceeded the target goal of the 65th percentile. Dramatic results were seen in the mean score for satisfaction with nursing (Figure 3).

Upon further analysis, the effects of Carolina Care were promising. Areas highly correlated to overall satisfaction and difficult to improve including

concern for privacy, meeting emotional needs, and attention to special and personal needs all showed positive trends (Figure 4). The most marked improvements were seen in the areas of pain control and response to call lights (Figure 5).

Carolina Care was initially implemented on all acute care units and then quickly adopted by critical care units and surgical services. Expansion to ambulatory care and diagnostic and therapeutic departments, such as admitting and radiology, is planned.

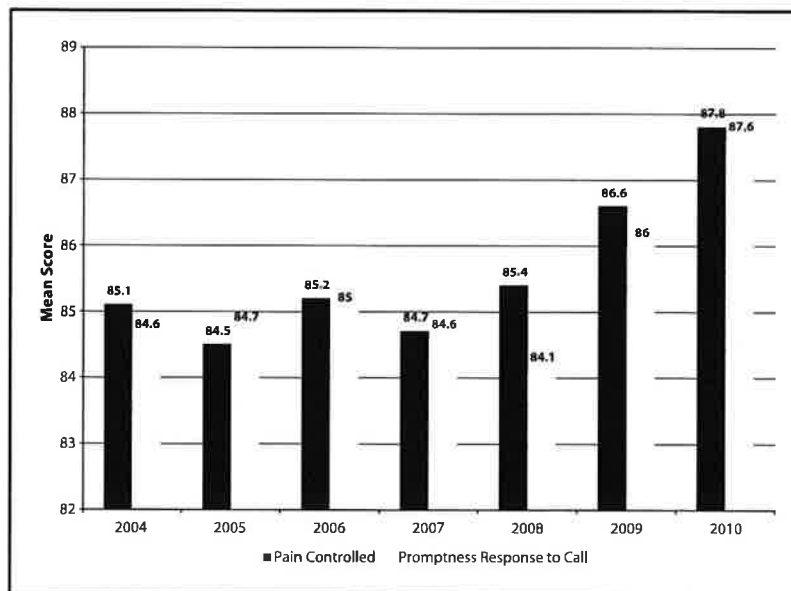


Figure 5. Annual UNCH patient experience metrics: mean score for satisfaction with pain control and prompt response to call light.

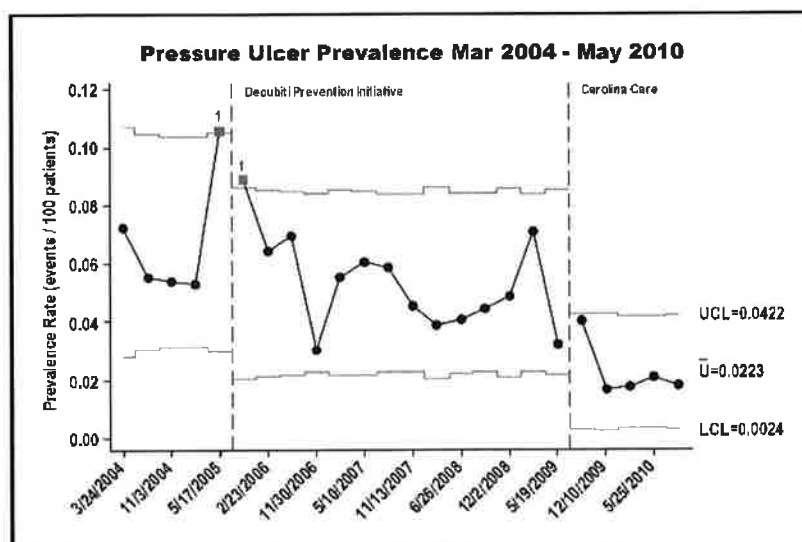


Figure 6. Carolina Care and prevalence of nosocomial ulcers.

The UNCH PPM and Carolina Care address both patient satisfaction and clinical outcomes. Next steps include a dashboard with measures of consistency in implementing Carolina Care correlated with patient satisfaction and National Database for Nursing Quality Indicators (ie, falls and nosocomial pressure ulcers). Nosocomial decubiti have been reduced by 50% since the implementation of hourly rounding and Carolina Care (Figure 6). The effect of Carolina Care on clinical outcomes continues to be the focus as UNCH strives to integrate these behaviors into the organizational culture.

### Conclusion

University of North Carolina Hospitals has developed a care delivery model that incorporates a core set of consistent behaviors and practices designed to translate Swanson Caring Theory into practice. Results indicate that substantive improvements in patient satisfaction occurred after Carolina Care implementation. Research is needed to study the relationships between Carolina Care interventions and Swanson caring processes. Initial performance improvement data suggest that hourly rounds may

be linked to better skin care outcomes. Evidence from systematic evaluation research is needed to support the existence of this relationship.

In addition to patient outcomes, this work raises questions about the role of caring behaviors in staff nurses' workplace well-being. Evidence from a number of studies suggests that caring has positive consequences for nurses.<sup>5</sup> Is caring a job characteristic that affects the job experience of the nurse as well as related outcomes (eg, job satisfaction, motivation, burnout, or stress)<sup>9,10</sup>? If so, what activities give rise to the experience of caring as a job characteristic<sup>11</sup>? Designing nursing care delivery models and jobs to actualize caring theory may have the potential to positively affect experiences and outcomes for both patients and nurses, and future research is indicated.

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