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Improving Knowledge and Attitude of Primary Healthcare Givers towards Vulnerable Populations: A Quality Improvement Project

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Section IV. Discussion

Abstract

Problem: This project aims to improve patient satisfaction for vulnerable population patients while in the hospital, namely transgender and gender non-conforming (GNC) individuals. A major roadblock for this population in seeking medical care is their fear of discrimination when accessing healthcare, resulting in a delay or avoidance of medical care. Multiple studies agree there is a need for nursing education on cultural competence to improve care and satisfaction for vulnerable populations.

Context: The site for this quality improvement project is a small suburban hospital within a large not-for-profit healthcare organization. The improvement team includes a clinical nurse leader student, social worker, transgender educator, assistant nurse manager, registered nurse (RN) champion, patient care technician (PCT) champion, and quality data operations specialist. A microsystem assessment was conducted using the Dartmouth Institute (2015) microsystem assessment tool, providing a blueprint for the project.

Intervention: The intervention for this project comprises in-services for RNs, PCTs, and unit assistants working in the microsystem of the fifth floor. In-service presentations include short films, group activities, and panel discussions. Education focuses on recognizing bias in care and respectful and inclusive care for all vulnerable populations, including transgender and GNC patients.

Measures: Data measurement includes a pre-project survey of an adapted National LGBT Cancer Network survey for RNs, pre- and post-intervention Watson caritas surveys for healthcare givers and patients, and quarterly HCAHPS scores for two nursing related questions.

Results: Results after project implementation showed a slight improvement in scores on the Watson survey for nurses and patients. Nurse self-reporting questions relating to self-care scored

the lowest, with the highest scores on the question asking nurse feelings of their values and beliefs contributing to personal success. Interestingly, patient scoring on the Watson survey had lowest averages on questions of nurses valuing their personal beliefs and faith, allowing for hope, and nurses providing loving care. Highest scoring questions were nurses treating patients with dignity, meeting basic human needs, and fostering trusting relationships. The HCAHPS scores on the microsystem unit for this project increased by one point each for the two nursing focused questions. The higher score represents a significant increase in patient satisfaction.

Conclusions: Conclusions point towards the positive influence nursing education has on patient satisfaction. Several additional contributing factors should be noted. Hospital leadership is beginning to stabilize, the interim manager on the microsystem unit is encouraging an inclusive environment, and RNs and PCTs from other departments have been invited to attend in-services. Registered nurses and PCTs are increasing their dialogue around bias and how to provide respectful care for all. As we move forward, there is interest and support in spreading this program to outside inpatient hospital areas. The emergency department and perioperative services staff, who are often the patient's first contact with the hospital setting, have shown the most significant support for the program. They have been proactive with encouraging their leadership to bring this program to their departments. The greatest value of the project is the opportunity to improve vulnerable patient healthcare outcomes.

Section II: Introduction

Scholars commonly describe the nursing profession as both science and art. In 2010, the American Nurses Association (ANA) wrote a policy statement describing the art of nursing, which encompasses the power to heal through caring and respect for human dignity (ANA, 2015). Gallagher and Polanin (2015) further identified the need for nurses in all healthcare settings to exhibit cultural competence when caring for vulnerable groups to achieve optimal health.

Although healthcare institutions are moving forward with policies to address the needs of vulnerable populations, there remains a disparity in caring for transgender and gender non-conforming (GNC) patients. Faught (2016) described this population as often reluctant and fearful to seek medical care; however, when nurses are culturally aware and provide patient-centered care, these barriers decrease.

Problem Description

In March of 2018, an acute care hospital in Northern California began performing *top surgery* for transgender male patients. During a recent survey of primary staff, most felt they were not knowledgeable about caring for this population or for the lesbian, gay, bisexual, transgender, queer (LGBTQ) population, in general. The result of this gap in knowledge created bias with care and stressful relationships with co-workers who identify with this population.

The Hospital Consumer Assessment of Healthcare Provider Systems (HCAHPS), a Center for Medicare and Medicaid Services (CMS) patient satisfaction survey, and People Pulse, a staff engagement survey given to all employees at the medical center, further identified areas for improvement. The results from the two surveys were consistently low for questions surrounding courtesy and respect for both groups. After reviewing data from staff satisfaction

scores, it became evident that improved cultural competence for all vulnerable populations was needed.

Cultural competence and cultural sensitivity are two phrases used when discussing the need for healthcare professionals to successfully care for patients who differ from their own culture (Gallagher & Polanin, 2015). The authors further discuss the importance for healthcare professionals to understand and respect these differences while providing individual patient-focused care. The nurse, who spends the majority of time with the patient, has a significant influence on patient outcomes, and only through ongoing education and training can cultural sensitivity be achieved.

PICOT Question

The PICOT question used in the search of literature was: (P) In hospitalized lesbian, gay, bisexual, transgender, queer (LGBTQ) patients over the age of 16, how does ongoing formal cultural sensitivity education for nursing staff (I), compared to usual care, (C) influence patient satisfaction and patient compliance (O) during hospitalization and after care (T)?

Available Knowledge

There is limited available knowledge on this topic; however, when widening the search to include cultural sensitivity for all vulnerable populations, evidence is strong. An electronic search of the CINHAL database, using the key words *transgender, LGBTQ, cultural sensitivity,* and *cultural competence,* was conducted. The following filters were applied: peer-reviewed journal articles and papers published after 2012. The search yielded 11 articles that met the search criteria, six of which were included for the review.

There is a common conclusion with all articles reviewed that strong nurse-patient communication is paramount to patient experiences and outcomes. Gallagher and Polanin (2014)

reinforced the need to increase cultural competence education for nurses in helping to reduce healthcare disparities for vulnerable groups. Gallagher and Polanin concluded the need for healthcare providers to individually tailor the care they provide and the importance of respecting and understanding cultural differences among their patients.

In a cross-sectional study, Rodriguez, Agardh, and Asamoah (2017) focused on transgender U.S citizens and self-reported discrimination accessing healthcare. Transgender and GNC people reported inequality in care, dependent on how they present. Rodriguez et al. concluded that there is a need for education with all healthcare providers. Kattari and Hasche (2016) studied how age relates to how transgender and GNC individuals perceive their experience with discrimination, harassment, and victimization. As with previously discussed studies, the authors identified the importance of education in the healthcare community in decreasing negative experiences and improving outcomes for these populations.

Stewart and O'Reilly (2017) documented concerns of the LGBTQ community with nurses not respecting preferred patient names or pronouns and the need to break the cycle and change the culture of heteronormativity. Garneau and Pepin (2015) highlighted the need for developing trust and relationship building with patients. Reinventing the care provided, changing usual practice, and offering continual education opportunities are all necessary to reduce disparities with vulnerable populations. Current literature supports inclusion of education and training for healthcare professionals. Riggs and Bartholomaeus (2016) reinforced the important role healthcare professionals have on improving experiences of transgender and GNC individuals in healthcare settings, which in turn will lead to improved compliance and outcomes.

After a robust search, all studies found to support this project were qualitative. Included studies are rated high quality, L111A, by the John Hopkins Research Evidence-Based Practice Appraisal Tool. Results are summarized in Appendix B evaluation table.

Rationale

Understanding cultural competence and moving forward to provide culturally sensitive care can be guided by Madeleine Leininger's Culture Care Theory. This humanistic theory describes nurse-patient relationships to promote health and wellbeing (Petiprin, 2016). The Leininger theory advocates for cultural education to begin in nursing school and to continue throughout one's career to address the diverse and ever-changing patient populations.

Leininger recognized that nurses provide the majority of care for a patient when in the hospital, and they have the most significant impact on a patient's experience in the hospital. The culturally competent nurse individualizes care for the patient, addressing needs while adapting and evaluating as care continues (Petiprin, 2016). Leininger's Sunshine Model further promotes this theory. The Leininger model lists three modes to guide nurses through the caring process. Ongoing education allows nurses to retain newly acquired knowledge, adapt to changes in practice, and restructure old patterns of care (Petiprin, 2016). Nurses are encouraged to recognize the differences and similarities they have with each patient and strive to communicate respectfully and inclusively, achieving positive patient outcomes.

Jean Watson's Theory of Caring Science further guides this project. Watson (2008) has love and caring as the center of all nursing practice. She states that when one recognizes their true self and is loving towards themselves, they are then able to be entirely present for their patients and can treat them with respect and love. In turn, treating patients with human dignity improves healthcare outcomes (Watson, 2008). Core concepts of the Watson theory and caritas

patient and staff surveys are part of the education planning (see Appendix F for caritas sample surveys). Watson's core concepts include 10 carative factors that include highlighting the importance of developing trusting relationships with patients, cultivating sensitivity, and promoting transpersonal teaching-learning (Watson, 2008). These three concepts are at the core of staff education.

Specific Project Aim

Improve patient satisfaction scores to a composite score greater than 20 on the Watson Caritas Patient Score survey by October 30, 2018.

Section III. Methods

Context

A microsystem assessment was conducted using the Dartmouth Institute (2015) microsystem assessment tool, which provides a blueprint of areas of focus, including purpose, patients, professionals, processes, and patterns, to assist in improving patient care, while acknowledging the importance of frontline staff. Looking at a microsystem in the same scientific means we treat patients and following a process as the Five Ps framework will improve clinical practice and the care and outcomes of patients (Nelson, Batalden, Huber, & Godfrey, 2007). Assessment findings for the microsystem 5 West include purpose, patients, professionals, processes, and patterns.

Purpose

A culturally sensitive education team formulated a mission statement: To support culturally diverse staff in caring for culturally diverse patients, who are often marginalized when accessing healthcare. Team members had a robust discussion, which culminated in identifying specific needs of staff and program goals for the microsystem:

- Improve trust and communication of the microsystem staff.
- Understand the unique aspects of caring for vulnerable populations.
- Understand and reduce the barriers vulnerable population patients experience when seeking healthcare.
- Improve patient care and patient satisfaction when hospitalized.

Patients

The patient population of this hospital is one of the oldest in the organization’s facilities. This patient population is also one of the most educated and healthiest in the nation. The top

diagnosis categories for the patients served include orthopedic, cardiovascular, pulmonary, gastrointestinal, neurological, and oncology diseases. The majority of patients are discharged home, often with family help and home health visits, or to an acute skilled nursing facility.

Professionals

The microsytem functions with an interdisciplinary team comprising three shifts. Each shift consists of an assistant nurse manager (ANM, one FTE), registered nurse (RN), four to five FTEs), patient care technician (PCT, two to four FTEs for day and evening shift and 0.2 FTEs for night shift), unit assistant (UA, two FTEs for day and evening shift and 0.2 FTE for night shift), patient care coordinator (PCC, 0.5 FTE for day shift), social worker (0.25 FTE for day shift), and physical therapist (0.5 FTE for day shift). There is one nurse manager for two units and a nursing director for six units, available day shift. Hosptialists (two FTEs) and surgeons (three to four FTEs) make multidisciplinary rounds daily between 9:00 a.m. and 10:00 a.m. Hospitalist (0.25 FTE) rounds on the unit at 10:00 p.m. daily.

Processes

The microsystem has clearly defined processes for admissions, transfers, and discharges, and staff surveyed had mixed comments on areas that work well and those needing improvement. The general consensus is that admissions go well, although time consuming, and there is added pressure of arriving patients from the emergency room within a 60 minute timeframe. From the data collected, nursing assessment documentation is inconsistent with timing. The expectation is for assessments to be completed within the first two hours of a shift and documentation is to occur in *real time*. Less than 50% of the time assessment and documentation is completed within this timeframe. Hourly patient rounding is an expectation that wavered and now has renewed support and oversight by ANMs, in hopes of improving patient safety and patient satisfaction.

Patterns

Staff indicated a lack of oversight and support from management. There has been a high turnover in management at all levels, and the unit manager at this time is interim. Scheduled staff meetings are often cancelled, and staff expressed a desire to be more of an active participant when meetings resume. Each shift has a five minute huddle at the beginning of the shift, where the ANM makes important announcements and often gives words of encouragement. The unit often has nursing student cohorts from three different schools, as well as two senior students with individual preceptors.

SWOT Analysis

A strength, weakness, opportunity, and threat (SWOT) analysis was conducted to determine internal and external factors that may influence implementing this program. Major strengths include the support of the organization's regional leadership and a diverse staff open to increasing their education and improving practice. Weaknesses and threats to program implementation include high turnover and instability of local management, leading to low staff morale; lack of knowledge by interim management of the local patient population and regional initiatives; and budgeting cutbacks for education and meetings. Opportunities that may arise from program implementation are improved staff morale, teamwork, patient satisfaction, and compliance. See SWOT analysis in Appendix E for additional factors.

Proposed Budget

The total estimated cost of this project will be $5,750 for the microsystem. Hospitals with high HCAHPS scores are awarded approximately $25,000 per question. This global aim of the project is to raise two of the HCAHPS questions, affording the hospital a potential for $50,000 in revenue. Deducting the project cost, the return on investment could yield $44,285 for the

hospital. There are additional benefits of this program that were not quantified. These include improved staff satisfaction, leading to better retention and improved standing in the community as an inclusive and safe facility for all individuals, which could lead to increased membership for the healthcare organization. See Appendix G for budget overview.

Intervention

The intervention for this project consists of cultural competence education in-services for RNs, PCTs, and UAs working on 5 Medical/Surgical. Teaching modalities include a combination of presentations, short films, group activities, and panel discussions. In-service content includes education on implicit and explicit bias, transgender, and GNC patient care. See Appendix H for the materials for implementation. Unit-based teams will conduct continuing education activities.

Study of the Intervention

The measurement strategy includes a global aim of improving patient satisfaction for all inpatients at the facility by October 30, 2018. The population criteria includes RNs and PCTs working on a medical/surgical unit. The data collection method will include data collected from the adapted National LGBT Cancer Network survey, Watson caritas surveys for healthcare givers and patients, and HCAHPS. Data will be collected pre-implementation for RNs and PCTs and then quarterly as the project continues. Patient and staff caritas surveys will be collected weekly, while HCAHPS and People Pulse data will be collected and reviewed monthly. See Appendix C for project charter measurement strategy.

The plan, do, study, act (PDSA) cycle was implemented for studying a test of change. The objective of the first PDSA was to engage an interdisciplinary team, including microsystem frontline staff, in planning an education in-service on caring for inpatient transgender and GNC patients after receiving *top surgery*.

Plan questions included the amount of time needed for in-services for staff to feel comfortable when caring for this population of patients, in-service content, and education methods. The team is to meet once a week for three weeks. Before the first team meeting, we gave all staff an online adapted National LGBT Cancer Network survey to guide staff need and also the Watson Caring Science Self-Reporting Survey to identify staff satisfaction.

Observations from the data collected pointed towards dissatisfaction with the work environment and lack of team collaboration. Staff felt they were knowledgeable with transgender and GNC terms, pronoun use, and differentiating between gender identity and sexual identity; however, they did not feel they understood transgender people, their concerns, and the lack of trust all vulnerable people have with the healthcare community or how to be more supportive of people with differences from their own.

It was determined that an initial in-service for 90 minutes would allow for combined method education, questions and answers, and sharing of personal stories. The team will expand content to cover all vulnerable populations in improving care for all.

The final step was advertising and conducting in-services for microsystem staff. After 75% of the microsystem staff attended the in-service, patients were given the Watson Caring Science Patient Survey at time of discharge. Staff repeated the Watson self-reporting survey 30 days after the last in-service.

Measures

The outcome measure for the project is increased patient satisfaction. Process measures include an RN knowledge and attitude survey on caring for vulnerable population patients and Watson caritas self-rating score, a survey developed by Jean Watson's Caring Science Institute. A

balancing measure for this project will be improved microsystem morale and team communication. See Appendix C for project charter, data sources, and targets.

Ethical Considerations

The nursing code of ethics guides nursing practice. Two sections of Provision 1 of the code were considered when planning the project.

> Section 1.2 Relationships with Patients – This section focuses on the need for population-centered care and care for all people without bias.
>
> Section 1.3 The Nature of Health – Nurses are to respect the dignity and rights of all people and their support should carry over to family and significant others. (Fowler, 2015)

Nurse and staff engagement in planning and implementing in-services for this project is crucial for nurse buy-in and to improve patient care (Gallagher & Polanin, 2014). Improving cultural competence for all staff reduces bias towards patients and each other (Garneau & Pepin, 2015). This is essential when building relationships with patients.

This project has been approved as a quality improvement (QI) project by the faculty using QI review guidelines and does not require IRB approval (see Appendix A, IRB Non-Research Determination Form).

Results

Following the implementation of the in-services, there has been an improvement in patient satisfaction scores on two HCAHPS questions. Question 1, which asks if patients were treated with courtesy and respect by nursing, improved from 4 to 5; Question 2, which asks if nurses listened carefully, improved from 3 to 4. Post-implementation scores on the Jean Watson caritas surveys showed a slight improvement in patient and nurse scores. Patient scores increased

from an average of 4.3 out of 7.0 to 5.6 out of 7.0. Patient scoring had lowest averages on questions of nurses valuing their personal beliefs and faith, allowing for hope, and providing loving care. Highest scoring questions were on nurses treating patients with dignity, meeting basic human needs, and fostering trusting relationships.

The anonymous surveys, along with a brief instruction sheet, were handed to each patient/family by UAs and the nurse educator. A possible limitation to this process is the role of the person handing out the survey, potentially influencing patient participation and scores. Patients receiving surveys from the educator may have had more detailed explanations.

Nurse scores had little variance. The pre-implementation average score was 5.3 out of 7.0 and 5.6 out of 7.0 post-implementation. Nurse self-reporting questions relating to self-care scored the lowest, with the highest scoring on the question asking for the feeling of their values and beliefs and if they contribute to personal success (see Appendix F for survey results).

The most significant increase can be seen in the 1-point per question increase in HCAHPS scoring on two nursing related questions. Floor 5 microsystem improved their scores from 4 to 5 on the question asking if patients were treated with courtesy and respect by nursing and from 3 to 4 on nurses listening carefully to the patient. The increases contributed to the overall improvement of the hospital's HCAHPS Stars Rating, giving an overall score of 5, as compared to 4 during the previous rating period. The hospital, especially Floor 5, has struggled with improving scores for many quarters. These results also reflect the impact of improved stability in leadership. This increase supports the return on investment for this project (see Appendix G for budget overview)

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Section IV. Discussion

Summary

Registered nurses and PCTs have commented, since implementing this project, they have a new positive focus to improve their practice. Written comments on in-service evaluations ranged from staff recognizing their own bias, to how they see the importance of this type of education facility-wide to improve patient care and satisfaction. See Appendix F for survey results and in-service evaluation comments. There remains reluctance from a few in leadership to adopt new programs, which may be due to budget concerns. Additional contributing factors for improved scores should be recognized: leadership has stabilized in several departments, daily patient rounding by ANMs has increased, and the new chief nursing executive fosters an inclusive environment. Staff is being encouraged to participate in activities promoting their growth and projects to implement relevant evidence-based practices.

Conclusion

Frontline staff are increasingly looking for ways to make a positive difference for their patients and to improve their practice. The facility continues to care for a diverse population, and offering education focusing on vulnerable populations will foster this improvement. The RNs and PCTs from other departments have asked their managers to include this program in their education. There has been excitement and sharing of ideas on ways to expand and improve education. The interventional radiology department received the initial presentation, and there are upcoming presentations for the perioperative department. Several nurses from the perioperative department have asked to visit other hospitals who provide surgery to transgender patients and to become care champions for their peers.

The clinical nurse leader functioning as an advocate, educator, and team manager will continue to engage frontline staff at all levels of project planning and implementation to ensure staff buy-in, leading to improved patient care. An increase in HCAHPS scoring yields higher reimbursement for the facility, contributing to a successful return on investment for this project and increasing the chances of support from senior leadership, who may be reluctant to add another project to their tight schedules.

Next steps will include engaging a patient advisory council to participate in planning for ongoing cultural sensitivity staff education. The most significant value of this project is the potential for improved healthcare outcomes for patients. According to Jean Watson (2008), when we approach all patients with respect and loving care, the healing process truly begins.

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Appendix A. Statement of Non-Research Determination

CNL Project: Statement of Non-Research Determination Form

Student Name: Kim Shankel

Title of Project:

Improving Knowledge and Attitudes of Primary Healthcare Givers Towards Vulnerable Populations: A Quality Improvement Project

Brief Description of Project:

A) Aim Statement: Improve knowledge and attitudes of primary healthcare givers towards vulnerable populations, namely transgender, and gender non-conforming people by November 30, 2018.

B) Description of Intervention: Cultural competent/cultural sensitive inpatient nursing staff education and training, focusing on LGBTQ appropriate care.

C) How will this intervention change practice? Increased LGBTQ cultural awareness and sensitivity to patients and family will improve communication and patient's experience while in hospital.

D) Outcome measurements:

Outcome:

Improve patient satisfaction, measured by Watson Caring Science Caritas patient score.

Process:

RN Knowledge and attitude survey on caring for LGBTQ patients, measured by adapted National LGBTQ Cancer Network survey guidelines. Hospital Consumer Assessment of Healthcare Providers Systems (HCAHPS) questions: 1. During this hospital stay how often did nurses treat you with courtesy and respect? 2. During this hospital stay how often did nurses listen carefully to you? Measured by National Research Hospital Stoplight Report

Balancing:

Improved microsystem morale and communication, measured by Watson Caritas RN self-rating score and People Pulse results.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**X**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**X**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**X**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**X**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**X**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**X**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

Appendix B. Evaluation Table

PICOT Question

In hospitalized lesbian, gay, bisexual, transgender, queer (LGBTQ) patients over the age of 16 (P) how does ongoing formal cultural sensitivity education for nursing staff (I) compare to usual care (C) influence patient satisfaction and patient compliance (O) during hospitalization and after care (T)?

Study	Design	Sample	Outcome/Feasibility	Evidence Rating
Gallagher & Polanin (2015)	Systematic review & meta-analysis	25 studies including a cultural competence training program and a measure of students' cultural competence.	There is varied effectiveness of interventions addressing an increase in cultural competence. Incorporating an educational program for nurses and staff, including role-playing and simulation, would be feasible and beneficial for all inpatient microsystems.	L lll A
Garneau & Pepin (2015)	Grounded theory	24 participants - 13 nurses & 11 nursing students in their final year of a baccalaureate nursing program.	Several realities must come together to provide culturally competent care. Relationship building, working outside usual practice guidelines, & reinventing practice are crucial to include when developing cultural competence. Useful to justify need and to guide development of programs.	L ll A
Kattari & Hasche (2016)	Secondary data analysis	Residents from all 50 states, including Washington, DC; Puerto Rico; & Guam. Individuals self-identified as transgender and/or GNC. Age groups: below 35, 35-49, 50-64, & 65 & above.	Transphobia is common. Older age groups experienced less discrimination and harassment, but experienced greater victimization than younger groups. Older ages less likely to report discrimination. Private or public insurance determines level of harassment and discrimination. Healthcare provider response to transgender and GNC individual is dependent on the individual's gender presentation.	L ll A

			Useful to support education and training to the healthcare community to decrease negative experiences and outcomes.	
Riggs & Bartholomaeus (2016)	Secondary data analysis	96 mental health nurses in six of eight Australian states or territories. 72% female, 28% male.	The nursing profession lacks guidelines and resources for transgender care of clients, specific to their practice. Nurses need to be aware of sensitivity, ethical issues, and challenges when providing care. This study reinforces the need for the nursing profession to improve care of transgender clients through increased nurse education/training.	L lll A
Rodriguez et al. (2017)	Cross-sectional study	Data retrieved from the National Transgender Discrimination Survey. 6,101 transgender and gender non-conforming participants were included - all of whom identified themselves as U.S. citizens and had felt discriminated against in a healthcare setting.	A third of participants reported feelings of discrimination in healthcare settings. People recognizable as transgender felt greater discrimination in healthcare settings. Raising healthcare professionals' awareness of discrimination towards transgender individuals, including cultural competence training, are key to reducing barriers. This supports the need for education and guides areas of focus.	L lll A
Stewart & Oreilly (2017)	Systematic integrative review	Qualitative, quantitative, and mixed-methods primary studies from 2006-2015 were assessed and 24 papers were included in the synthesis.	Nurses and midwives often lack knowledge of LGBTQ population healthcare needs. Their beliefs and attitudes, which often are influenced by heteronormativity, can have a negative impact on patients receiving appropriate care. This is useful for supporting need of research, policy making, and professional development.	V A

Appendix C. Project Charter Measurement Strategy

Charter

Project Charter: Improving Knowledge and Attitudes of Primary Healthcare Givers towards Vulnerable Populations: A Quality Improvement Project

Global Aim: Improve knowledge and attitudes of primary healthcare givers towards vulnerable populations, namely transgender, and gender non-conforming people by November 30, 2018.

Specific Aim: Improve patient satisfaction scores to a composite score greater than 20, on the Watson Caritas Patient Score survey by October 30, 2018.

Background:

Scholars commonly describe the nursing profession as both science and art. In 2010, the American Nurses Association (ANA) wrote a policy statement describing the art of nursing, which encompasses the power to heal, through caring and respect for human dignity. Gallagher & Polanin (2015) further identify the need for nurses in all healthcare settings, to exhibit cultural competence, when caring for vulnerable groups, to achieve optimal health.

Although healthcare institutions are moving forward with policies to address the needs of vulnerable populations, there remains a disparity in caring for transgender patients. Faught (2016) describes transgender patients as often reluctant and fearful to seek medical care, however when nurses are culturally aware, and provide patient-centered care, these barriers decrease. The CNL proposes a nursing education program focusing on cultural awareness and sensitivity to the LGBTQ patient, to provide improved patient outcomes and increased patient satisfaction. Gene Watson's Caring Science will be the basic framework for the program.

Sponsors

Chief Nursing Executive	K. C.
Nursing Director Interim	T. R.

Goals:

1. Develop and implement a series of pilot in-services for primary healthcare caregivers.
2. Increase the knowledge and improve attitudes of primary healthcare givers caring for LGBTQ patients.
3. Improve patient satisfaction while in hospital.

Measurement Strategy

Background (Global Aim): Improve knowledge and attitudes of primary healthcare givers towards vulnerable populations, namely transgender, and gender non-conforming people by November 30, 2018.

Population Criteria: Registered Nurses (RN) and Patient Care Technicians (PCT) working on 5 West Medical/Surgical unit and LGBTQ patients admitted to the same unit.

Data Collection Method: Data will be collected from the adapted National LGBT Cancer Network survey, Watson Caritas surveys for healthcare givers and patients, and HCAHPS. Data will be collected pre-implementation for RNs and PCTs then quarterly as project continues. Patient and staff Caritas surveys will be collected pre and post in-service and HCAHPS data will be collected and reviewed monthly.

Data Definitions

Data Element	Definition
LGBTQ Patient	Self-described LGBTQ patient inpatient.
RN	RN working on medical surgical unit.
PCT	PCT working on medical surgical unit.
In-Service Survey	Adapted National LGBT Cancer Network Survey Guidelines. This survey was developed to gather data to address disparities in care for LGBT cancer patients and the LGBT community in general.
Caritas Self Rating Score	Watson Caring Science Survey.
Caritas Patient Score	Watson Caring Science Survey.
Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS)	Standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care.
People Pulse Survey	Staff Survey providing insights into employee satisfaction. Topics include, relationships, remuneration and benefits, and work environment.

Measure Description

Measure	Measure Definition	Data Collection Source	Goal
Patient Satisfaction	1. During this hospital stay how often did nurses treat you with courtesy and respect? 2. During this hospital stay how often did nurses listen carefully to you?	National Research Corporation Stoplight Report	1. ≥ 92.9% 2. ≥ 85.5%

Measures

Measure	Data Source	Target
Outcome		
Increase patient satisfaction	Watson Caring Science Caritas Patient Score	20
Process		
RN knowledge and attitude survey on caring for vulnerable population patients	Adapted National LGBT Cancer Network Survey Guidelines	90%
Watson Caritas Self-Rating Score	Watson Caring Science Survey	20
Balancing		
Improved microsystem morale and communication	Watson Caring Science RN People Pulse Results	20

Team	
RN Assistant Nurse Manager	L. V.
RN Champion	S. Q.
Quality Data Operations Specialist	A. Q.
Patient Care Technician Champion	J. C.
Social Worker	D. S.
Transgender Team Educator	T. R.

Driver Diagram

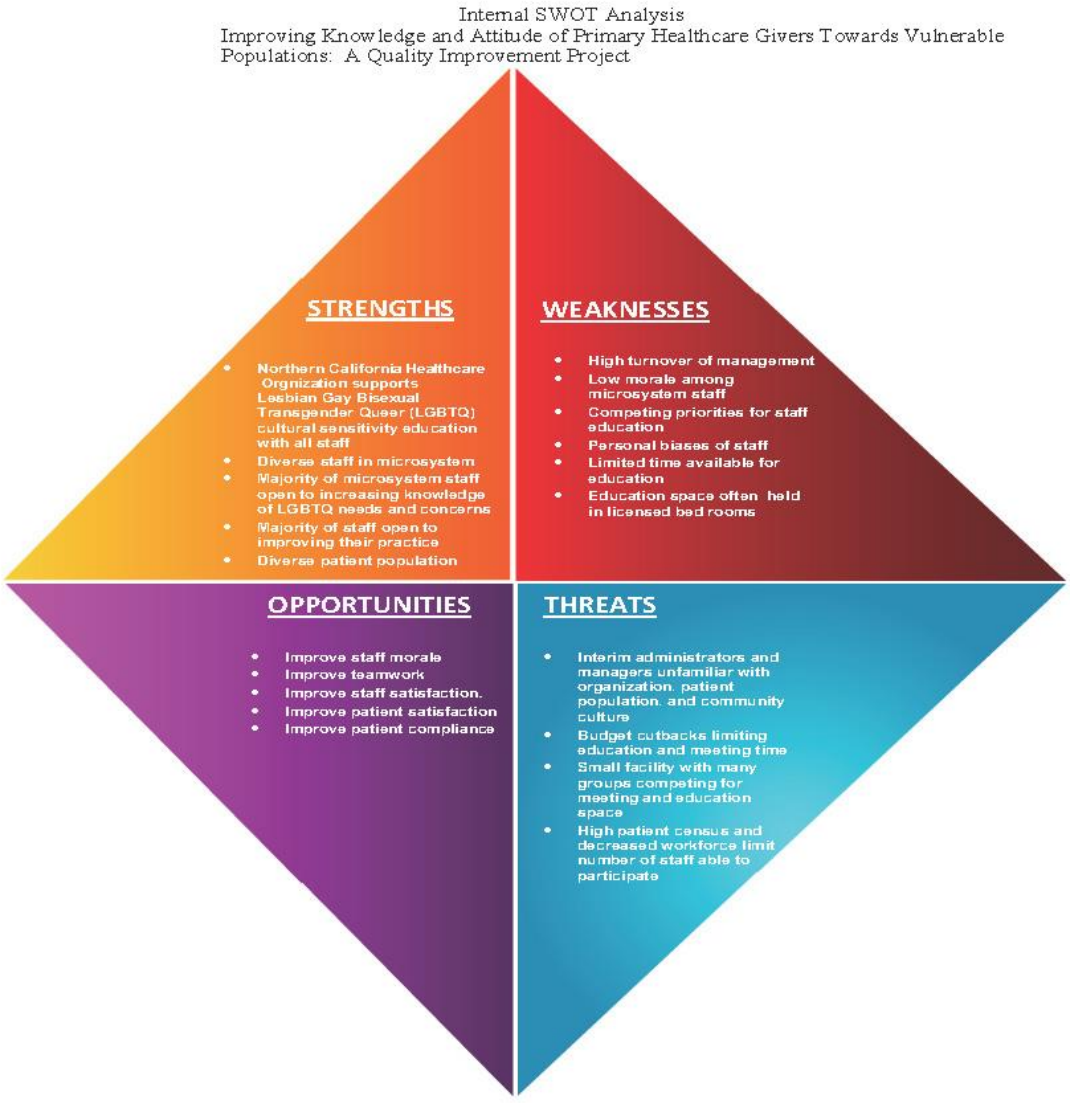
Appendix D. GANTT Chart

MSN CNL Project: Improving Knowledge and Attitudes of Primary Healthcare Givers Related to Vulnerable Populations

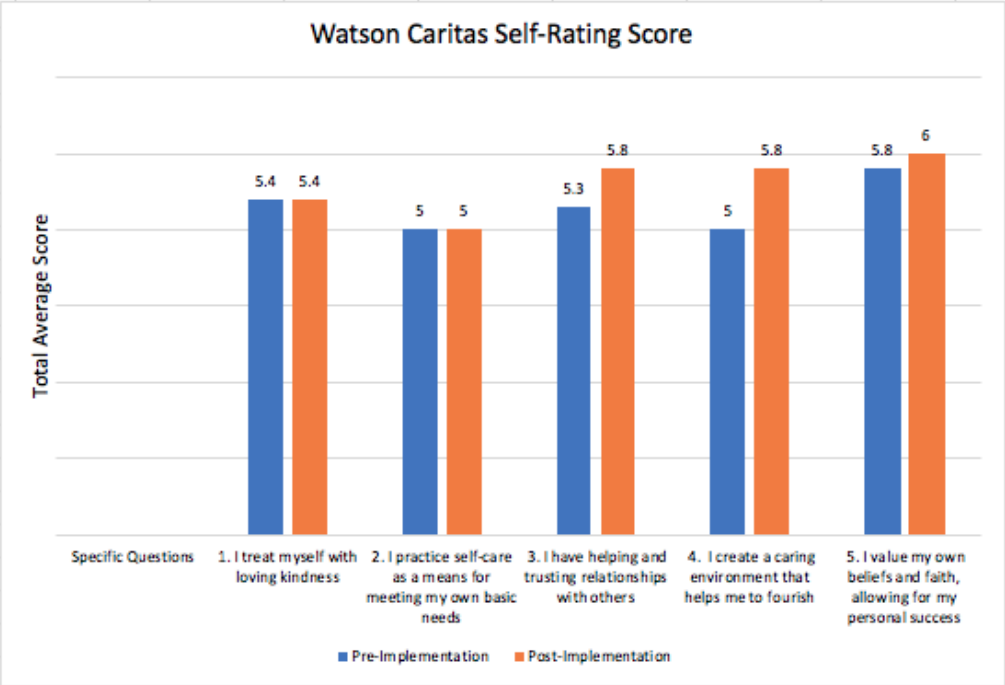
GANTT Chart

Steps	Description/Name of Person Assigned	Responsible Party(ies)	2018 Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Status
1	Microsystem Assessment	K. Shankel									Completed
2	Project Charter Draft	K. Shankel									Completed
3	Meet with USF Professor & Preceptor	K. Shankel, C. Coleman, & Preceptor									Completed
5	Meet with Hospital Admin	K. Shankel									Completed
6	Meet with Interdisciplinary Project Team	K.Shankel, Frontline Staff, ANM, Social Worker									Completed
7	Develop Pilot In Service	K.Shankel & Frontline Staff									Completed
8	Initial Staff and Patient Surveys	K. Shankel & ANM									Completed
9	First In services	K. Shankel, social worker, frontline staff									Completed
10	Post Patient & Staff Surveys	K. Shankel & ANM									Completed
11	Gather Data and Analyize	K. Shankel & Quality Op Specialist									Completed
13	Finalize Project	K. Shankel									Completed

Appendix E. Internal SWOT Analysis



Appendix F. Survey Results and Sample Surveys



Sample Staff Survey

Watson Caring Science Institute

Watson Caritas Self-Rating Score©

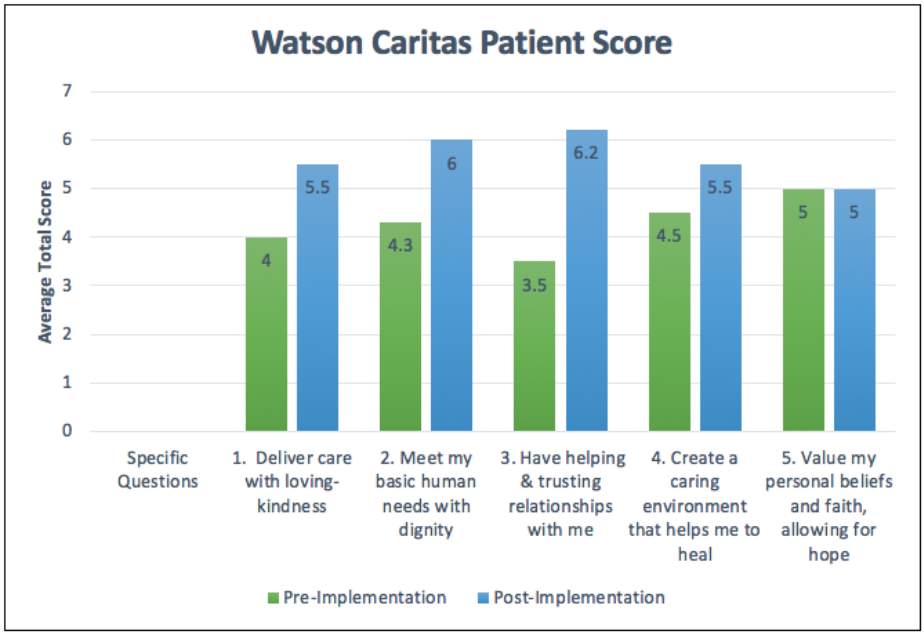
DIRECTIONS: When answering the questions, please consider the overall consistency of human-to-human **Self** CARING you have experienced. Please circle the number for the one best answer.

	Never						Always
I treat myself with loving-kindness.	1	2	3	4	5	6	7
I practice self-care as a means for meeting my own basic needs.	1	2	3	4	5	6	7
I have helping and trusting relationships with others.	1	2	3	4	5	6	7
I create a caring environment that helps me to flourish.	1	2	3	4	5	6	7
I value my own beliefs and faith, allowing for my personal success.	1	2	3	4	5	6	7

I would recommend this hospital to someone I love:

Yes ☐ **No** ☐

We invite you to share any notable caring or uncaring moments you have experienced.



Sample Patient Survey

WCPS ver. 2b

Watson Caring Science Institute

Watson Caritas Patient Score®

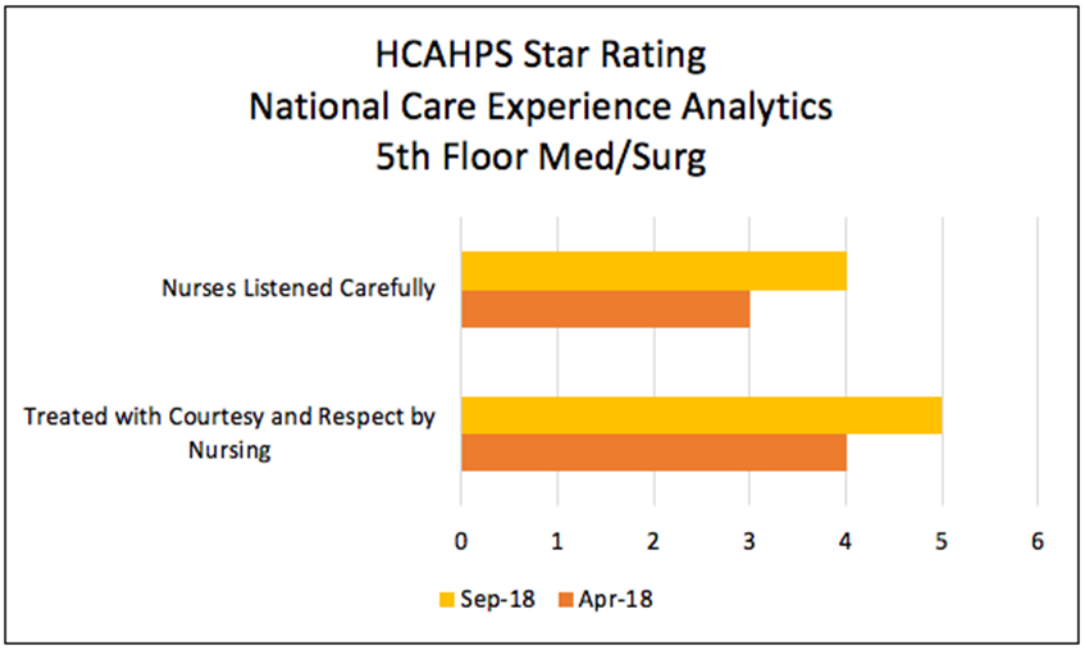
DIRECTIONS: When answering the questions, please consider the overall consistency of human-to-human CARE you have received **during this hospital stay**. Please circle the number for the one best answer.

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

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

Thank you for completing our questionnaire!

Watson Caritas Patient Score®



In-Service Evaluation Comments

Questions	Verbatim Responses
Comment on the style of teaching/learning methodologies used.	"Including active participation and time for questions and answers was helpful. Sometimes presentations are not interactive." "Personal stories were a good touch." "Non-judgmental when answering questions. Thank you" "Bias activity should be mandatory for all. I didn't understand the difference between explicit and implicit bias or that we all are biased."
Overall comments/ suggestions.	"I wish we had more time for this class and it was mandatory for all employees." "I thought I was a sensitive nurse but there is so much I didn't know about the transgender population and how I can improve care to them." "MDs need this presentation too." "How can I be a unit champion and help with continuing education?" "We all need to treat our patients and each other with more understanding."

Appendix G. Project Budget

Improving Knowledge and Attitude of Primary Healthcare Givers towards Vulnerable Populations: A Quality Improvement Project

Category	**Type**	**Amount**	**Balance**
Cost Avoidance HCAHPS	25,000 x 2 Measures	$50,000	$50,000
Cost to Implement			
Staff 2 hour In-service RN – 25 x 97.50 per hour incl benefits	Expense	($4,875)	$45,125
Staff 2 hour In-service PCT & UA-9 x 30 per hour incl benefits	Expense	($540)	$44,585
Supplies-Reams of Paper, Envelopes	Expense	($150)	$44,435
Refreshments for In-services	Expense	($150)	$44,285
Cost Benefit			$44,285

Appendix H: Material for Implementation

Sample Educational In-Service Outline

Culturally Sensitive Care for Our Transgender & Gender Non-Conforming Members

Learning Objectives:

Upon completion of the class each participant will be able to:

- Describe, explain, and differentiate culturally sensitive care for LGBTQ patients.
- Differentiate implicit & explicit bias, recognize what happens during stressful situations, and describe how it affects care for vulnerable population patients.

Agenda

10 min. Welcome and Introduction

20 min. Bias pptx and activity recognizing our own biases - The Trusted 10

45 min. LGBTQ pptx with focus on transgender & gender non-conforming people.

4 min. video - Introduction to Transgender People by the National Center for Transgender Equality, group practice using preferred pronouns, simulation RN shift handoff.

15 min Reflection and Q & A