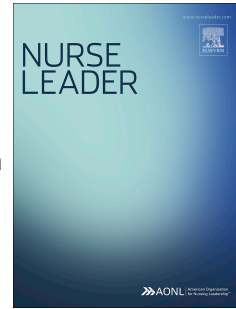


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The Impact of Compassionate Connected Care on Safety, Quality, and Experience in the Age of COVID-19

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Abstract:

Compassionate Connected Care improves safety, quality, and experience of care. In the age of COVID-19, it is even more critical. The care model and strategies to deliver it are underpinned by quantitative and qualitative data and provide a roadmap for caregivers during this unprecedented crisis.

In this unprecedented human crisis that is COVID-19, caregivers and care recipients alike reevaluate the meaning of the word *suffering*. All of us are suffering during this pandemic. There is pain, fear, death, exhaustion, loss, and uncertainty about the future. Our lives and livelihoods are at risk, and survival is paramount. Compassion and connection are more important than ever.

Because patient experience metrics are among the performance outcomes used to assess care quality and value, there is a greater appreciation that the patient experience is not about making people happy or keeping them satisfied. It is now understood to reflect a broader construct that encompasses clinical, operational, cultural, and behavioral components of patients' experience and the people who care for them across the continuum of care.

Patient experience is also more than a set of metrics. Often, healthcare executives' day-to-day work leads to a focus on metrics, scores, and productivity. But every metric is a person with a life, a family, hobbies, jobs, and things of importance, so it is essential to consider this holistic perspective when considering what the metrics represent and what optimal performance on them looks like. One way to move beyond the numbers, percentile ranks, and reimbursement to remind healthcare leaders of the real impact healthcare has on those who come to them for care is to bring the data to life through stories.

In 2015, a young family with two young children, a 3-year-old and a 7-month-old went to dinner with their extended family on a Sunday evening. After a lovely dinner, my husband, Aaron, left for work. Aaron, who was not quite 30 years old, enjoyed his third year as a police officer on the night shift. His

wife, Amanda, took the children home, and Aaron went to work. At 2:30 in the morning, Amanda's doorbell rang. She was afraid, home alone with her babies in the middle of the night, so she called Aaron. He didn't pick up. He couldn't, because an hour before those two police officers came to the door, he had been shot in the head in the line of duty. He had been shot through the left eye. Amanda rode to the hospital with those two police officers, not knowing if her husband was alive or dead. She arrived just before Aaron was being taken into surgery, with just enough time to whisper in his ear, "You must fight for your babies."

After the surgery, the neurosurgeon came out and took her hands and said, "We've taken off half of his skull to let his brain swell, we've placed him in a medically induced coma, he's lost his eye. Best case scenario: he'll never speak again, and he'll have limited use of his right side." The surgeon was empathetic, genuine, and honest, but it was devastating. Amanda had no control, she was scared, and she had no idea what the rest of her life would be like. She was entirely at the mercy of everyone taking care of Aaron. Like Aaron, every person in the health care system in a bed, on a gurney, or in a waiting room represents the data points, the scores, and the metrics. Amanda is my daughter, and this journey to the optimal patient experience is personal.¹

What the Data Tells Us

The overarching goal in health care across the continuum must be the reduction of suffering. Before this pandemic, suffering may have seemed too subjective to really measure. On the contrary, it is measurable. We've measured it since we began asking patients to rate their care experience. The questions in experience surveys ask patients and caregivers to tell us the needs they have that are met or not met. If needs are not met, suffering ensues. Suffering involves both avoidable and inherent stress and distress. Avoidable suffering is that which is imposed upon patients. For example, when teams don't work well together, patients must wait for care or results, when rooms are not clean and quiet

when caregivers don't listen and respond to concerns. Inherent suffering occurs with the diagnosis and treatment of disease, even when health care delivery is perfect. Inherent suffering can and should be mitigated, but avoidable suffering must be eliminated.² This is a tall order. It requires constant, vigilant, collaborative, data-driven, and patient-centered work.

Health care leaders often focus on metrics that score lower, anticipating that by addressing the low-scoring concerns, performance on global patient experience measures, including Overall Rating and Likelihood to Recommend, will improve. However, that is not always the case. Press Ganey researchers reviewed responses to more than one million patient experience surveys to determine key drivers of patient loyalty and experience across the continuum. The findings demonstrated that low scores on food and parking don't drive the performance on global measures. Instead, key drivers of loyalty in the provider practice include confidence in the skill of your provider, teamwork, and concern for patient worries (Figure 1).³

In the acute care setting, key drivers include teamwork, nurse courtesy, and cleanliness. There are many disciplines involved in patient care across the continuum. Patients see many people and are told many different things. They need to know that the people taking care of them are talking to each other and following the same care plan. It is important to note that nurse courtesy is often a proxy for all staff courtesy because patients in a stressful and sometimes chaotic hospital environment cannot always identify roles and titles. This means that responses to nursing care or courtesy questions are not limited to registered nurses; every person in the organization impacts and, therefore, owns the patient experience. Room cleanliness is also a key driver – now, more than ever. When the patient perceives the room to be clean, they infer that the entire organization is clean and less likely to get an infection. During this time, few things are more important than keeping people safe from infection. These are essential drivers because they all link to safety.⁴ When patients trust their provider when the care team works well together as a team, when caregivers talk to patients and listen to them and involve them in

their care, when the patient room and bathroom are clean, patients feel safe. When patients feel safe, they are more likely to be compliant, more likely to trust their providers, and, as a result, more likely to say they had a good experience.

Research in the emergency department (ED) demonstrated similar loyalty findings to medical practice and acute care settings. Although the prevailing opinion about patient experience in the ED is that wait time has the strongest influence on patients' Likelihood to Recommend the ED, that is not the case. As indicated in Figure 3, the top drivers in the ED are all about communication, connection, and information. Focusing on these key drivers of the patient experience rather than on scores is much more meaningful to people who take care of patients every day. If the goal is to be at the 90th percentile, that's the wrong goal. The goal must be to optimize the experience of the people who come to your organization for care and the experience of the people who care for them.

Figure 1. Key Drivers of Loyalty in Provider Practice

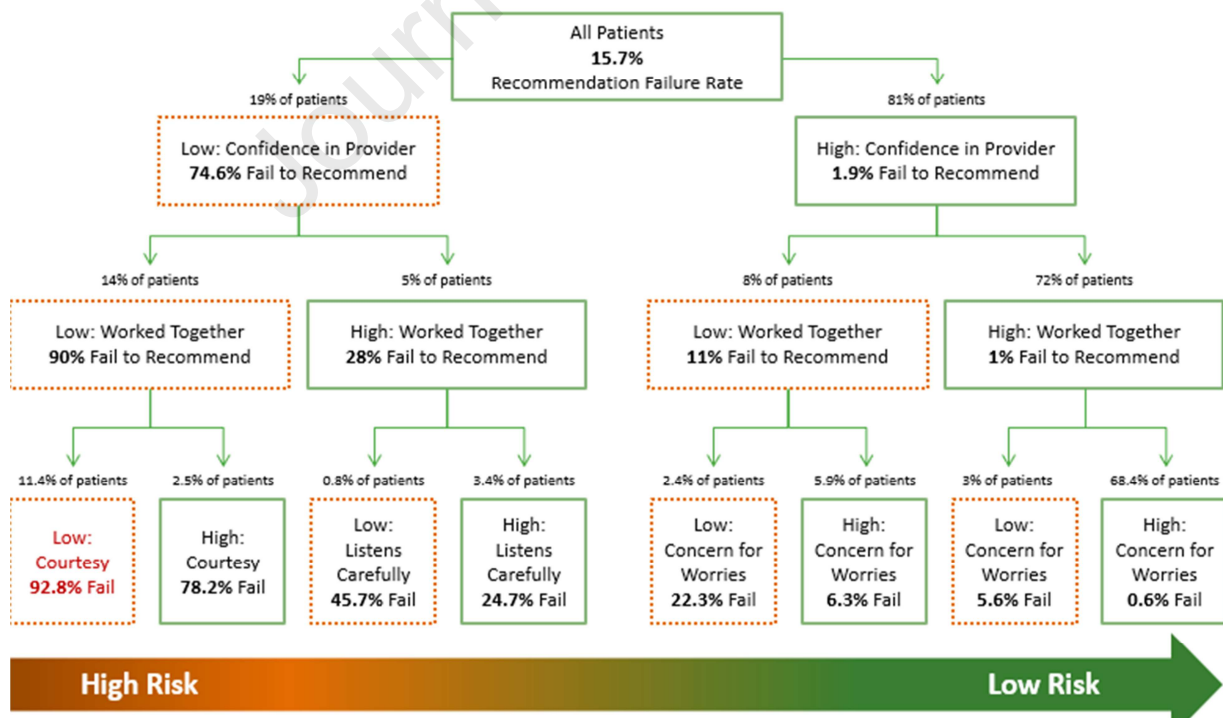


Figure 2. Inpatient Key Driver Analysis

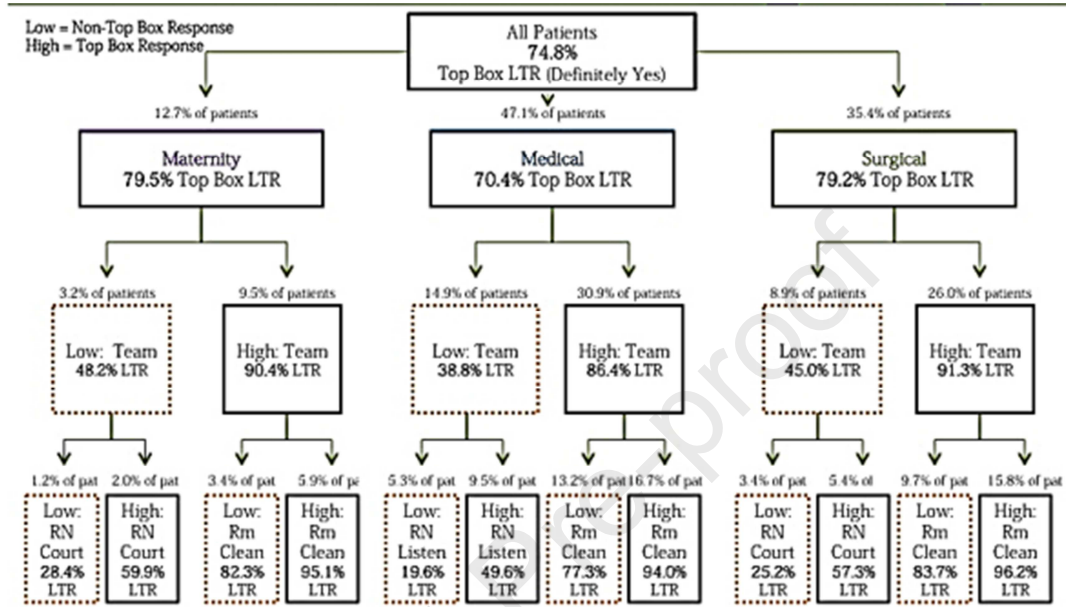


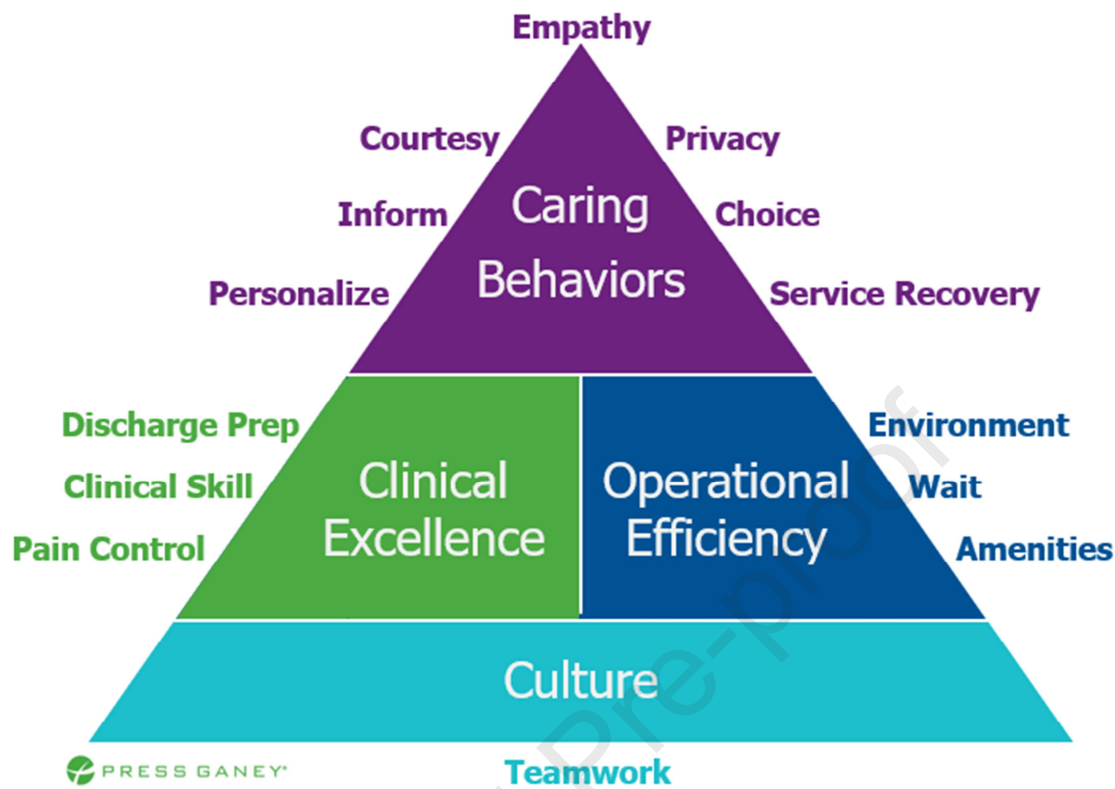
Figure 3. Emergency Department Key Drivers

		Correlation to Likelihood to Recommend
Personalized Care	Staff cared about you as a person	0.79
	Kept informed about delays	0.72
	Pain controlled	0.72
	Doctor's concern for your comfort	0.72
Information	Doctor kept you informed	0.71
	Staff kept family/friends informed	0.71
	Nurses' kept you informed	0.71
	Information re self care at home	0.71
Pain Control	Nurses' attention to your needs	0.70
	Doctor listened to you	0.69
Empathy	Courtesy toward family or friends	0.69
	Nurses listened to you	0.68
	Courtesy of the doctor	0.68
	Wait in treatment area to see doctor	0.66
	Courtesy of the nurses	0.65
	Nurses' concern for your privacy	0.63
	Allow family/friend to be with you	0.62
	Waiting time pre treatment area	0.58
	Helpfulness person first asked re condition	0.58
	Comfort of the waiting area	0.57
	Concern for comfort blood draw	0.53
	Courtesy person took blood	0.53
	Wait for radiology	0.53
	Privacy re personal/insur info	0.52
	Ease giving personal/insur info	0.52
	Courtesy person re personal/insur info	0.51
Waiting staff noticed your arrival	0.51	
Discharge Prep		

Compassionate Connected Care™

Talking about suffering and measuring it are not enough. To eliminate avoidable suffering, health care leaders must understand the totality of the patient experience. Figure 4 shows the Compassionate Connected Care™ model and how the question themes fall into each of the domains.⁵

Figure 4. Compassionate Connected Care™



The three words of the CCC framework were chosen very carefully. Compassion without clinical excellence is helpful but not sufficient. Clinical care without compassion leaves both patients and caregivers empty and devoid of real meaning. It is the connection between compassion and clinical excellence and the connections between caregiver and patient and among caregivers that makes the real difference in healthcare. This model and framework resonate with people who care for patients every day. It brings them back to why they do what they do and helps them find joy and meaning in the work. The data has demonstrated this in improved clinical quality, caregiver engagement, and patient experience.

Clinical excellence connects clinical care with outcomes. Operational excellence connects quality and efficiency. Behavioral excellence connects engagement with action. And Culture connects the mission, vision, and values of an organization with the engagement of the people who work there. Examining the data in this way helps organizations focus their efforts in ways that provide the most

improvement. An affinity diagram developed from hundreds of image statements from patients, clinicians, and non-clinicians to understand what compassionate and connected care looks like in practice identified the following themes.

- **Acknowledge suffering: Caregivers should acknowledge that patients are suffering and show them that they care**
- **Body language matters: Body language is as important as the words we use**
- **Anxiety is suffering: Anxiety and uncertainty are negative outcomes that must be addressed**
- **Care should be coordinated: Patients need to know that their care is coordinated and continuous and that providers are always there for them.**
- **Autonomy reduces suffering: Autonomy preserves patient dignity**
- **Real caring transcends medical diagnoses: Real caring goes beyond delivery of medical interventions to the patient**

These six simple themes resonate with people who care for patients every day. They are meaningful and bring them back to why they entered health care as a career, allowing them to return to true patient-centeredness, rather than asking them to focus on a score or mimic a hotel or theme park experience. However, in the age of COVID-19, caregivers find it challenging to do these things when they are terrified. PPE is inconsistent at best and non-existent at worse; isolation of patients creating loneliness and anxiety; constantly changing information; and ethical dilemmas the likes of which we have never seen in our lifetimes: who gets the ventilator and who dies? These are real today.

So, in the age of COVID-19, how do these themes apply?

The acknowledgment of suffering is essential for both patients and caregivers. Acknowledging the emotions and physical needs arising from this pandemic is critical to demonstrate that we, as caregivers or leaders, hear those concerns. Acknowledging the needs is the first step in helping people feel safe in your care. We may not be able to fix all the issues and, in this crisis environment, we know

that they cannot all be fixed. However, merely acknowledging that we hear their fears and distress, both physical and emotional, is the first step in making them feel safe. Statements such as, “Mrs. Smith, I can see that you are fearful and concerned that you cannot see your family when you are sick. This is a very contagious virus, so we have to minimize visitors to take care of the sick people here like you. I will help you stay connected by phone, email, or text while we take care of you and do our best to keep both you and your family safe.” Narrating care is especially important here – whether through technological means, gestures, signage, or verbal – to emphasize safety and transparency that helps both patients and providers feel safe.

Body language is still important even when we may not be able to enter the room. There may be no way to sit down or touch some of these patients. If it is possible to do this, it should be done – even with gloves and masks. For someone in isolation with no visitors, that simple gloved touch or words of connection from the door or window may mean the difference between feeling safe and cared for or terrified and alone. This is not ideal in a “normal” care environment, but this is not a “normal” environment, and it requires a different but still connected approach.

Healthcare, as a business, as professionals, as an industry, has never been under more stress. Patients, caregivers, and providers, and administrators are worried at best and terrified at worst. Most are somewhere in between. That anxiety is suffering, and anxiety magnifies the suffering that is both inherent and avoidable with disease and treatment processes and with system processes. This anxiety leads to less than optimal patient experience, clinical quality, safety, and engagement. Transparency of information helps to alleviate anxiety. Emerging and adaptive practices by some healthcare organizations living through the COVID-19 surge demonstrate that healthcare leaders who provide daily updates to their organization using real-time technologies foster trust. Key performance indicators that show COVID-19 admissions, discharges, deaths, people under investigation, staff infections, quarantined employees, and supply inventories are shared in these forums so that there is awareness at all

organization levels. In this environment, there is no way to overcommunicate. In the absence of information, it is human nature to fill in the gaps. Leaders must ensure that the data is timely, accurate, and empathic so that people do not fill the gap with misinformation that adds to the problem. This is paramount to build, foster, and maintain trust.

While the coordination of care is often difficult, many organizations are relaying that they have never seen teams work so well together as in this time of unprecedented stress. This kind of collegiality and collaboration should be applauded and fostered well beyond the current crisis. A positive root cause analysis in the immediate period after the surge will help identify those specific attributes that led to the team's positive performance so that after the crisis, those attributes and team performance are replicated and become highly reliable. A positive root cause analysis may be performed in the same way that a root cause analysis determines the processes or systems that led to a negative outcome but, instead, identifies the *positive* processes or systems that led to a *positive* outcome so that the behaviors become sustainable.

Merriam-Webster defines autonomy as “self-directing freedom and especially moral independence”.⁶ Nothing about this crisis makes patients or health care professionals feel self-directing or morally independent. Therefore, we must provide choice and the ability to decide about one’s care or work whenever possible. If a choice can be made, no matter how trivial it may seem to either a patient or a caregiver, it should be provided as a choice. Allowing people to participate in decision making helps them feel safe and more in control in a completely out of control situation.

Most importantly, real caring transcends the diagnosis of COVID. The photos and stories we see in the media are a testament to this fact. Patients and caregivers are not merely statistics. They are people with families, hobbies, jobs, and other aspects of their lives that they most care about. When they are separated from the most important things to them, taking 56 seconds to connect with them in

a way that shows they are more than the COVID patient on a stretcher in the ED will mean as much or more to the caregiver as it does to the patient. As leaders round, either virtually or in-person, remembering one thing about the employee or merely acknowledging a specific action that an employee did for another person suffering during this crisis will help employees realize that the work they do matters in a chaotic, unpredictable, and scary world.

While COVID-19 has dramatically changed how we deliver care, these themes are still essential and drive outcomes. Transformation is the intersection and convergence of safety, clinical quality, and experience delivered by an engaged and resilient workforce. However, when considering a crisis like COVID-19, Maslow's hierarchy can help us prioritize our efforts. In his 1943 paper "A Theory of Human Motivation," Abraham Maslow represented human development and motivation as a pyramid.⁷ At the base of the pyramid, he placed the needs he regarded as most fundamental. Upon this base, he layered a series of additional needs, each of which could only be satisfied after meeting lower-level needs. He postulated that the human need for safety was quite basic, subordinate only to physiologic needs such as shelter, food, water, and sex. People could only satisfy other, higher needs such as love, esteem, and self-actualization if they felt safe. Caregivers and patients alike deal with devastating impact on Maslow's hierarchy's most fundamental and foundational aspects. With the economic decline from the social distancing and virtual shutdown of commerce in the US, patients and caregivers are concerned about losing their homes and unable to buy or even find food. People are worried for themselves and for their families with the inability to be tested for this virus. Caregivers are concerned that they don't have the resources to do their jobs safely: PPE, beds, staff, ventilators, and safe places to sleep if they can sleep at all. When this occurs, it is difficult to think about compassion, and it seems impossible to connect in a meaningful way.

But there is hope. Never has the healthcare community bonded together across state lines, across licensures, and in such selfless ways as today. Flights are filled with healthcare workers going to

hotspots to help. Companies are holding contests to make more masks – even the homemade kind.

Healthcare leaders are foregoing their salaries so that those hardest hit by the economic crisis keep their jobs and make ends meet for their families. Technology is being used in ways that allow isolated patients and their families to remain connected. Innovation enables caregivers to utilize equipment located in isolation patient rooms to be controlled outside the room and allow more than one patient to be ventilated using only one of those precious resources. Hope Huddles are gaining traction so that caregivers see that what they do right now in this unprecedented time matter, and many patients do survive thanks to their efforts. Healthcare leaders share information like never before so that the care of both patients and caregivers improves for all. This is true compassionate connected care in action.

Health care providers will never actually realize the impact they have on the lives of the people they care for. As providers, we must recognize that our patients will remember what we said, what we did, and how we made them feel forever.

Aaron beat the odds. He can drive now. He can play with his kids and argue with his wife. He will have language and cognitive problems forever, but he's alive and independent, and their family has a new normal. This is thanks to all the people in the acute hospital, the rehabilitation hospital, his providers, his nurses, his therapists, and everyone else he interacted with across the care journey. Without them, the outcome would have been much different. This is why the outcome is about more than a score. We will continue to have similar stories from this pandemic.

Shanafelt, Ripp, and Trockel (2020) discussed findings from eight listening groups of physicians, nurses, advanced practice providers, residents, and fellows what they are most concerned about. Access to PPE, exposure to COVID and family transmission, testing availability (and results), uncertainty about the organization's commitment to self and personal needs if infected, access to childcare, support for other personal and family needs, being competent if deployed to a new area, and lack of access to information and communication were most cited. These might be viewed in the context of safety as

well. Fear and uncertainty with a need for safety in practice and personal lives make it very difficult to focus on anything beyond that need. The authors broke these concerns into healthcare professionals' requests to their organizations during this pandemic: Hear me, protect me, prepare me, support me, care for me.

Trust in leadership has never been more critical for caregivers. Trust may be viewed in three components: Authenticity, Empathy, and Logic (Frei and Morriss, 2020). People are more likely to trust an organization when they understand the motivations and believe they are authentic. Building upon this authenticity is that people must believe that leaders care about them or are empathic and have a rationale for their actions (logic). Press Ganey (2020) provided useful tactics and strategies related to each of these trust-building blocks that leaders should consider. (Figure 5)

Figure 5. Trust Building During COVID-19 Surge

Authenticity	<ul style="list-style-type: none"> • Visible leadership rounding • Asking how people are doing • Clear, concise communications • Transparency on metrics, planning
Empathy	<ul style="list-style-type: none"> • Hotels/dorms to house staff to prevent infection of family • Provision of scrubs/showers prior to leaving • Convenience services (e.g., food at work, grocery delivery) • Addressing hardships (e.g., sharing of PTO for furloughed staff) • Communicating successes (e.g., number of extubations, number of discharges) • Celebrating clinical success (e.g., songs for COVID-19 discharges) • Debriefs post-code • Code Lavender crisis intervention strategies to support health care workers • Community appreciation/media • Real and virtual kudo boards/positive comments • Virtual post-shift debriefs to support staff • Promoting resilience <ul style="list-style-type: none"> ▪ Oasis rooms ▪ Caregiver checklist to identify where support is needed ▪ Wellness buddy ▪ Psych/behavioral health professionals and chaplains ▪ Mental health rounding ▪ Drop-in counseling ▪ Town halls addressing stress ▪ Guided meditations ▪ Instituting/augmenting peer support ▪ Acknowledging likelihood of PTSD and proactively supporting
Logic	<ul style="list-style-type: none"> • Incident command structures/daily problem-solving • Visible planning for process, physical resources, and personnel resources <ul style="list-style-type: none"> ▪ Establishing COVID-19 units ▪ Sourcing PPE and ventilators ▪ Processes for conserving PPE ▪ Creating new staffing models ▪ Redeploying furloughed staff for new roles ▪ Leader succession planning in case of illness • Maintaining communication regarding metrics, capacity, and planning • Visible evidence of safety practices to protect staff • Streamlining work (e.g., anterooms to don/doff PPE to enhance efficiency) • Removing barriers (e.g., instituting telemedicine, IRB approval within hours) • Conducting pulse surveys to assess needs and supports for staff on the front line

Most organizations want to be highly reliable for their patients and their caregivers. As defined by Weick and Sutcliffe (2001), the five principles of high reliability also apply to trust and leadership. Deference to expertise is a way to demonstrate the trust characteristic of empathy because leaders

show respect for others. Preoccupation with failure is authentic when leaders show concern for staff and patient safety. Sensitivity to operations promotes the trust characteristic of logic because leaders promote communication and frontline leader and caregiver situational awareness and decision support. Reluctance to simplify also promotes reasoning when leaders dig deeper to understand the causes and solutions. Finally, commitment to resiliency demonstrates empathy when leaders develop systems and processes that can bounce back in the face of crises.

This pandemic and its response must be chronicled at the national, state, and local levels and at the individual and department levels. How patients and caregivers perceive care, engagement, quality, and safety will help prepare for the next crisis and help take the learnings from this pandemic to change healthcare for the foreseeable future. The data coming out of this crisis will be fundamental. It will tell the story of the caregivers' heroism and the experience of the people who got sick. It will explain what is truly important to people in a time of unspeakable crisis to be better prepared going forward. Storytelling is how we make the data come to life and make it real for those who care for patients. We will have no more important story to tell than the one we are living in today.

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Top Key Points:

- 1) Compassionate Connected Care of patients and caregivers has never been more important than in the current pandemic.
- 2) Data demonstrates the impact and alignment of patient, caregiver, and clinical quality outcomes.
- 3) The need for patients and caregivers to feel safe and to trust the people caring for them are fundamental to optimize outcomes and change healthcare during this pandemic and beyond.