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**MASTER OF ARTS IN NURSING**

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**EFFECT OF WATSON’S CARE (COVID 19 AWARENESS AND RELATED  
EXPERIENCE) PROGRAM TO REDUCE ANXIETY LEVEL OF HEALTH CARE  
WORKERS DUE TO COVID 19 IN A TERTIARY HOSPITAL IN QUEZON CITY,  
PHILIPPINES**

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March 2025

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### **EFFECT OF WATSON'S CARE (COVID 19 AWARENESS AND RELATED EXPERIENCE) PROGRAM TO REDUCE ANXIETY LEVEL OF HEALTH CARE WORKERS DUE TO COVID 19 IN A TERTIARY HOSPITAL IN QUEZON CITY, PHILIPPINES**

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Acceptance Page

This Thesis of **JANE IVAH ONGPAUCO** titled: “**EFFECT OF WATSON’S CARE (COVID 19 AWARENESS AND RELATED EXPERIENCE) PROGRAM TO REDUCE ANXIETY LEVEL OF HEALTH CARE WORKERS DUE TO COVID 19 IN A TERTIARY HOSPITAL IN QUEZON CITY, PHILIPPINES**” is hereby accepted by the Faculty of Management and Development Studies, U.P. Open University, in partial fulfillment of the requirements for the degree **Master in Arts of Nursing**.

  
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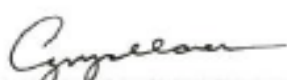
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## Biographical Sketch

**Jane Ivah P. Ongpauco** was born on November 2, 1985, in Quezon City. She pursued a career in nursing and obtained Bachelor of Science in Nursing from Far Eastern University in 2006. Throughout her academic journey, she demonstrated a strong passion for healthcare, patient care, and nurse management.

As a dedicated nurse, she has gained valuable experience in pediatric cardiovascular nursing from 2007 until 2018 providing compassionate and evidence-based care to patients. She was then promoted as a Head Nurse of Adult Executive Suite and Private wards from 2018 until present. She has also actively participated in various professional development programs, research projects, and healthcare initiatives to enhance patient outcomes.

Beyond her professional career, she is deeply committed to lifelong learning and contributing to the nursing profession through research and advocacy. This thesis, titled "Watson's ***CARE (COVID-19 Awareness & Related Experience) Program on Reducing Anxiety Levels Among Health Care Workers Due to COVID-19 in a Tertiary Hospital in Quezon City, Philippines***" reflects her dedication to advancing knowledge in research.

## **Acknowledgement**

First and foremost, I would like to express my deepest gratitude to God for giving me the strength, wisdom, and perseverance to complete this thesis.

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## **Dedication**

This study is wholeheartedly dedicated to my beloved family, whose unwavering support and encouragement have been my greatest source of strength. To my parents and siblings, for their unconditional love, guidance, and constant motivation and to my friends for believing in me in every step of the way.

This study is also for those who strive for knowledge and perseverance in the face of challenges. This thesis is a testament to the love, patience, and sacrifices of those who stood by me.

## **Abstract**

The COVID-19 pandemic has significantly impacted the mental health of healthcare workers (HCWs), particularly those in isolation due to infection. This study investigates the effectiveness of Watson's CARE (COVID-19 Awareness & Related Experience) Program in reducing the anxiety levels of HCWs at the Philippine Heart Center. Grounded in Jean Watson's Theory of Human Caring, the study utilizes a structured intervention comprising clinical caritas processes designed to foster a caring and supportive environment for isolated HCWs.

A quasi-experimental research design was employed, with participants divided into an intervention group receiving the Watson's CARE Program and a control group receiving standard care. Anxiety levels were measured before and after the intervention using the State-Trait Anxiety Inventory (STAI). The results indicated a significant reduction in anxiety levels among HCWs who participated in the program, highlighting the importance of structured caring interventions in improving mental well-being during health crises. These findings support the integration of Watson's CARE Program into nursing practice to enhance emotional resilience and patient care quality.

Keywords: CARE Program, COVID-19, Nurses, Nursing

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## **Chapter I**

### **THE RESEARCH PROBLEM**

#### **Background of the Study**

During the early phase of the pandemic COVID-19 in the Philippines, psychological impact of this outbreak includes anxiety, stress levels and depression to patients. (Tee et al., 2020). The inherent anxiety bound to the uncertainty of their health condition, patients experience non-caring encounters in ward admissions (Nystrom, Dahlberg & Carlsson, 2003; Goransson, & von Rosen, 2010; Andersson, Jakobsson, Furaker, & Nilsson, 2012). As a result, the impression of an indifferent atmosphere can result in heightened anxiety and reduced coping skills for the patient. It is, therefore, imperative to come up with interventions grounded on a caring theory to meet not only the physiological patients' needs, but also their psychosocial aspect.

Several theorists have enunciated to importance of caring. Nursing, according to Dr. Jean Watson, is purely caring; and thus, no life-saving intervention or procedure can be referred to as "nursing" without "caring." Watson made nursing values, knowledge and practices explicit in the form of "Clinical Caritas Processes" that are geared toward subjective inner healing. Watson's concept of caring for individuals can be applied as an approach aiming to incorporate caring interventions in the care for emergency department patients. Though how patients perceive nursing care highly depends on the care they receive, factors (i.e. age, residence, educational level, gender and perception of illness) which influences patients' perception of nurse caring behaviors were identified (Baldursdottir & Jonsdottir, 2002).

A multitude of studies exploring caring behaviors have been made over time. Correlations were also drawn between nurses' compassionate actions and patient contentment in interventional cardiology (Wolf et al., 2003), operating theater (Palese et al., 2011); and medical-surgical wards (Azizi-Fini et al., 2012). In an emergency setting, caring behaviors of nurses were positively viewed by patients (Merrill, Hayes, Clukey, & Curtis, 2012). In an intensive care unit, nurse caring behaviors was identified by Pryzby (2005) as factors that alter family stress responses. Moreover, interventions based on caring framework have also been investigated. For example, Richardson (2012) wrote that an improved patient care experience resulted from improved staffs' ability to create an intentional caring consciousness. Carabetta and colleagues (2013) incorporated caring questions in their peri anesthesia nursing assessment tool and effectively communicated and addressed patients' requirements throughout their surgical experience. Nursing care models anchored in caring theories were also published. Watson & Foster (2003) identified an Attending Nurse Caring Model wherein nurses are held responsible for a comprehensive nursing care using the caring theory was effective in conveying and addressing the needs of patients throughout their caring needs. Another nursing care model that is grounded in a caring theory is the relationship-based care which was found to increase verbal and nonverbal caring behaviors (Winsett, & Hauck, 2011); improve patient safety and teamwork among maternity nurses (Hedges et al., 2012), and improve nursing care (Woolley et al., 2012).

Literature shows that a number of researches have been made exploring caring on different contexts. Nevertheless, as COVID-19 illness arouse, caring interventions tailored according to the needs of patients in the wards are of course found very limited. Conversely, wards handling COVID-19 patients nowadays have their own

policies and procedures defining their roles in specific situations. Nonetheless, specific interventions which convey caring to COVID-19 patients are uncommon. This study has resulted from a substantial effort to transform COVID-19 patients isolation into a place conducive for caring and inner healing.

The COVID-19 pandemic has necessitated the isolation of healthcare workers (HCWs) diagnosed with the virus, leading to increased levels of anxiety due to factors such as social separation, uncertainty about health outcomes, and the stress of being both caregivers and patients. Addressing this anxiety is crucial, not only for the well-being of the HCWs but also for their ability to provide effective care upon their return to duty. Jean Watson's Theory of Human Caring emphasizes the significance of a holistic, compassionate approach in healthcare, focusing on the interconnectedness of mind, body, and spirit to promote healing and well-being. Central to this theory is the establishment of a caring-healing environment and the development of authentic, trusting relationships.

It was the intention of this study to identify best caring practices that can be effectively applied in COVID-19 patients on isolation. The negative experiences of patients staying on isolation, which ranges from anxiety, boredom, depression and rapid deterioration of health condition, are substantial and calls for a need to implement interventions that will alleviate the cited perennial problems. This study attempted to offer possible solutions in the form of theory-derived caring interventions. The researcher selected health care workers as study participants because they are crucial for producing high-quality research that tackles significant issues in clinical practice. They were also chosen for their ability to foster relationships with administrators and other staff members within the institution.

This study aims to investigate the effectiveness of Watson's CARE (Caring, Awareness, Restorative, Empowerment) Program—a structured intervention grounded in Watson's caring principles—in reducing anxiety levels among HCWs isolated due to COVID-19 at the Philippine Heart Center (PHC). By aligning the study with Watson's conceptual framework, the research seeks to explore how intentional caring interventions can mitigate anxiety and promote psychological well-being among isolated HCWs.

The researcher was able to ascertain if human caring theory-based therapies effectively reduce patients' anxiety during isolation. Last but not least, the researcher believed that this study will significantly advance the use of evidence-based therapies in the treatment of COVID-19 patients.

### **Statement of the Problem**

The purpose of the study is to determine the effects of the Watson's Covid 19 Awareness and Related Experience (C.A.R.E.) Program in reducing the anxiety level of Health Care Workers with COVID19 at PHC, who are on isolation:

Specifically, this study was aimed to answer the following questions:

1. Is there a significant difference in the level of anxiety of the Health Care Workers with COVID-19 at PHC who are on isolation before and after intervention?
  
2. Is there a significant difference in the level of anxiety and the following variables:
  - a. Gender
  - b. Age
  - c. Educational level
  - d. Profession

e. Family Structure

### **Objectives of the Study**

#### **General Objective:**

1. To assess the impact of isolation on anxiety levels of the Health Care Workers with COVID-19 at PHC who are on isolation before and after intervention.

#### **Specific Objectives:**

1. To determine level of anxiety before Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program
2. To determine level of anxiety after Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program
3. To determine level of baseline characteristics of Health Care Workers before Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program
4. To determine the association of the level of anxiety and the following variables:
  - a. Gender
  - b. Age
  - c. Educational level
  - d. Profession
  - e. Family Structure

## **Significance of the Study**

The results of this study would convey beneficial information to the following:

**Nursing practice.** During this time of COVID-19 pandemic, identifying best caring practices affecting the level of anxiety of patients is an important step in supporting evidence-based practice initiatives. Also, this study enables nurses who are taking care of COVID-19 patients to meet the social obligation and provide a “caring relationship” regardless of the increasing demands the unit has.

**Nursing administration.** The researcher selected health care workers as participants in the study because they are crucial for producing high-quality research that tackles important issues relevant to clinical practice. They were also chosen for their ability to foster relationships with administrators and other personnel within the organization. This research presents to hospital managers that negative feedback about nursing care result from multi-factorial hospital issues. The challenge to improve COVID-19 patients satisfaction that require the support of the nurse leaders and managers, as well as hospital administrators.

**Nursing education.** The researcher selected health care workers as study participants because they play a crucial role in producing high-quality research that tackles important issues relevant to clinical practice. Additionally, they were chosen for their ability to cultivate relationships with administrators and other personnel within the organization.

**Nursing research.** The result of this study can be a tool for other researchers’ endeavor, most especially, those directed in improving taking care of COVID-19 patients.

**Patients and families.** The implementation of the interventions of caring according to Watson's theory of care will significantly benefit patients who are with COVID-19 since caring standards will hopefully allay their anxiety and have positive health outcomes during their isolation.

### **Scope and Limitations of the Study**

This study mainly focused on the effect of implementing interventions of caring according to Watson's theory of caring on the health care workers with COVID-19 who are on isolation. As the pandemic was lifted, PHC protocol on healthcare workers with mild to moderate COVID-19 symptoms includes isolation on their own home. While those healthcare workers with COVID-19 severe symptoms are admitted in PHC. The study primarily evolves in the concepts of "Clinical Caritas Process" enclosed in the theory. The study mainly examined the caring behaviors of nurses for the universal needs of all patients with COVID 19.

Watson's Program was used in this investigation. help lower the anxiety levels of PHC's COVID-19 healthcare workers who are isolated from the first day of their sickness until they are cleared to return to work. On the first day of their sickness and before they were cleared to return to work, completed self-report questionnaires were gathered. The tool utilized in this study was the Caring Behaviors Inventory-24.

PHC routine care of healthcare workers diagnosed with COVID19 is a communication with Infection and Prevention Control staff as they will interview through phone how they contacted the disease, and they will inform the HCW when is the start and end of the isolation period.

## Chapter II

### THEORETICAL BACKGROUND

The relevant literature and research, both domestic and international, pertaining to the study's variables will be provided in this chapter. The dispute, conflict management styles, perceptions of conflict management styles, and how these styles relate to profiles are all covered in this chapter.

#### Review of Related Literature

This chapter discusses the concepts related to this study.

#### Isolation and Anxiety

“Isolation has been identified as a significant factor contributing to increased anxiety levels, particularly among healthcare workers during the COVID-19 pandemic. The enforced separation from social and professional support networks can lead to feelings of loneliness, stress, and psychological distress.

A study published in *BMC Public Health* examined the perceived stress resulting from social isolation among clinical and non-clinical healthcare workers during the pandemic. The findings indicated that both groups experienced heightened stress levels due to isolation, with clinical staff reporting slightly higher stress, potentially due to the dual pressures of professional responsibilities and personal health concerns.

The relationship between isolation and anxiety is further supported by research highlighting the concept of social buffering, where social interactions play a crucial role in mitigating stress responses. The absence of such interactions during isolation can exacerbate feelings of anxiety and helplessness.

In the context of healthcare workers, prolonged isolation not only affects mental health but can also impair cognitive functions, decision-making abilities, and overall job performance. Addressing isolation through targeted interventions is essential to maintain the well-being and efficiency of healthcare professionals, especially during health crises like the COVID-19 pandemic.

By understanding the correlation between isolation and anxiety, healthcare institutions can develop strategies to provide psychological support, promote social connectivity, and implement programs aimed at reducing the negative impacts of isolation on their staff (Meese, et al., 2004).

### **Prevalence of Anxiety in Health Care Workers**

During the COVID-19, healthcare workers are exposed to a higher risk of anxiety symptoms. In total, 71 studies were included in this study. The pooled prevalence of anxiety was increased in frontline healthcare workers, then showed significant result on nurses, and medical doctors (Santabárbara et al., 2021).

“One-third of healthcare workers suffered from depression, and more than one-third suffered from anxiety during the COVID-19 pandemic. Healthcare workers should be monitored on increased measures of their mental health running a high risk of psychological distress during COVID-19 pandemic. Results of this study revealed pooled prevalence of depression, anxiety and heterogenicity” (Sialakis et al., 2023).

### **Anxiety in Healthcare Workers and Its Factors**

Ensuring the overall well-being of healthcare workers (HCWs), including their mental health and psychological well-being, is a critical aspect of patient care and the preservation of the healthcare workforce. This study aimed to evaluate the mental

well-being and emotional state of HCWs concerning depression, anxiety, and stress using the DASS-21 scale in a tertiary government hospital during the COVID-19 pandemic in the Philippines, as well as to identify the job-related factors that may be linked to these outcomes. A total of 364 healthcare workers participated in the study. The majority were single (62.62%), lived with immediate family (50.82%), and worked in COVID-designated areas (62.09%). A high prevalence of depression (49.18%), anxiety (61.54%), and stress (30.22%) was identified among the HCWs. Working in high infection/COVID-designated areas was significantly associated with anxiety and stress, while high job demand was significantly linked to all three mental health conditions compared to low job demand (Hilvano-Cabungcal et al., 2024).

Nurses exhibited a notably higher rate of depression and anxiety compared to doctors and medical technicians (depression: 54.5% in nurses vs. 48.1% in doctors, 46.7% in medical technicians). Furthermore, healthcare workers with low to medium income ( $\leq 8,000$  RMB) experienced a higher prevalence of depression compared to those with high income ( $\geq 8,001$  RMB), while no distinction was found between low- and medium-income groups (Zhou et al., 2024).

### **Interventions to Reduce Anxiety in Healthcare Workers**

Given the significance of evidence regarding interventions for mental health challenges among healthcare workers (HCWs) during pandemics, researchers performed a systematic review to identify and summarize interventions aimed at managing HCWs' mental health issues during infectious disease outbreaks, as well as to evaluate their effectiveness. They searched various electronic databases including Web of Science, PubMed, Cochrane, Scopus, CINAHL, and PsycInfo up to October 2nd, 2020.

News Medical 2024 reports that healthcare workers experience mental health challenges, including elevated levels of anxiety, at notably high rates. A global meta-analysis corroborates these findings, revealing similarly high incidences of mental health issues. Mental health stands on equal footing with physical health for healthcare professionals. To bolster resilience, strategies like mindfulness meditation and achieving a better work-life balance, complemented by interventions such as counseling and emergency helplines, are essential in addressing mental health concerns. Additionally, individuals should push for organizations to enhance mental health support within the healthcare sector.

### **Jean Watson's Theory of Caring**

Watson's theory emphasizes the significance of humanistic aspects of nursing combined with scientific knowledge, focusing on the interpersonal relationships between nurse and patient to promote healing and wholeness.

#### *Key Components of Watson's Theory:*

1. **Carative Factors:** Watson identified ten carative factors that serve as a guide to core nursing practices, including the formation of humanistic-altruistic value systems, instillation of faith-hope, cultivation of sensitivity to oneself and others, and the development of helping-trusting relationships.
2. **Transpersonal Caring Relationship:** This aspect emphasizes the deep connection between nurse and patient, aiming to protect, enhance, and preserve a person's dignity, humanity, wholeness, and inner harmony.
3. **Caring Occasion/Caring Moment:** Defined as the moment when the nurse and another person come together in such a way that an occasion for human

caring is created.

Watson's theory has been applied in various settings to address psychological distress. For instance, a randomized controlled trial investigated the effects of nursing care based on Watson's theory on distress, self-efficacy, and adjustment in infertile women. The study found that such care significantly reduced distress and improved self-efficacy and adjustment levels.

By integrating Watson's carative factors into interventions for healthcare workers isolated due to COVID-19, the focus shifts towards holistic care that addresses both physical and psychological needs. This approach fosters a supportive environment that can alleviate anxiety by promoting feelings of trust, empathy, and connectedness.

## **Caring**

Caring was defined by Watson as a value and an attitude that has to become a will, an intention, or a commitment that manifests itself in concrete acts (McCance et al., 1997). Pryzby (2005) refer nurse caring behaviors as a function of nursing attitudes, skills, and knowledge employed in the care of patients and families that serve to positively influence, support, and enhance nursing care (Arslan-Ozkan et al., 2013).

### *Factors Influencing Nurses' Caring Behaviors*

The concept of caring has been explored by a number of investigators. Prompahakul and colleagues (2011) categorized "factors relating to nurses' caring behaviors into personal, technological-influencing, and environmental factors." They claimed that age is associated with development and maturity level associating it to the caring behavior of a nurse. Their study also suggested that years of work

experience in nursing have a direct relationship with nurse's caring behavior. Educational level was also noted to have a significant impact on caring behavior of a nurse. In addition, nurse's self-awareness was found by the authors to have a positive correlation with caring behavior. Emotional intelligence was explained as a significant but low unique variance of caring behaviors and complex combinations between EI dimensions appear to be required for nurses to render caring behaviors. The authors also mentioned about technological-influencing factors and that the advancement in technology allows nurses to save time and effort which provides nurses more time to spend with patients. Environmental factors, such as the working unit, were deemed by the authors as a hindrance in providing quality nursing care. To illustrate, a shortage of nurses can result in poor quality of care because of increased workload. Lack of time was the most verbalized barrier to providing good care in hospital units.

### *Caring with COVID-19 patients*

The application of Jean Watson's Theory of Caring is still very limited for COVID-19 patients. According to Tintu (2021), Watson's caring theory and the caritas process highlight the importance of self-care to reduce psychological distress. Practicing loving-kindness is crucial for nurses, enabling them to care for themselves and extend that care to their patients. As nurses study Watson's caring theory, they recognize that suppressing their emotions is detrimental to their well-being. It is essential for nurses to find moments to release this energy and practice self-love to create and share a cohesive caring experience.

### *Caring Interventions*

In response to the threatened concept of care, a variety of interventions focusing on caring has been developed. A caring protocol was developed by Wolf, Bailey, & Effect of Watson's CARE (COVID 19 Awareness and Related Experience) Program to 13 Reduce Anxiety Level of Health Care Workers Isolated due to COVID 19 at Philippine Heart Center

Keeley (2014) which comprises of caring activities that was later formed as a standard of practice. Caring standards in ED have also been published (Kipp, 2001; StuderGroup, 2011).

Dinc & Gastman (2013) identified conditions vital to establish a helping / trusting environment. Montague, Chen, Xu, Chewning, & Barrett (2013) positively linked length of visit, social touch, and clinician-patient eye contact to the patient's assessment of clinician's empathy. Richardson (2012) created a project focusing on Caritas Processes #1, #3, #4, and #8 that provides a caring framework to evaluate shift report and hourly rounding processes. Carabetta, Lombardo & Kline (2013) incorporated caring questions in their hand-over reports to improve the patient care for perioperative patients. Using case studies within a caring framework helps the nursing staff better understand how verbal and non-verbal communication during change of shift report and hourly rounding can be therapeutic or harmful (Richardson, 2012). Similarly, the use of purposive hourly rounding as an intervention was found effective in improving the quality of care (Ontario Hospital Association, 2011; StuderGroup, 2011; Woolley et al., 2012).

Models of patient care have also advanced with the increasing conscious efforts to reignite nurse caring behaviors. Investigations show that caring models resulted to improved overall patient satisfaction (Tonges, & Ray, 2011). Drenkard's (2008) study which utilized human caring model of care evaluated the impact of reducing work intensity alongside implementing key caring behaviors. The results indicated improvements in staff's job fulfillment and improvement in co-working relationships. However, patient's perception of caring, pre-intervention and post-intervention were not statistically significant between control and experimental groups.

Studies which utilized RBC as an intervention revealed improvement in patient safety upward satisfaction trend (Hedges et al., 2012; Woolley et al., 2012); improved work environment and caring (Nelson et al., 2013); increased and sustained verbal and nonverbal nurse caring behaviors (Winsett, & Hauck, 2011); decreased nurse turnover (Winsett, & Hauck, 2011); significant increase in the teamwork among nurses (Mathes, 2011; Hedges et al., 2012) after implementation of RBC.

### **Factors Influencing Patients' Anxiety Level on Nurse Caring Behaviors**

The discussion in the research, 'The Impact of Nurses' Caring Behavior on Patient Satisfaction in Clinical Settings,' is presented narratively based on the findings of the study; the explanation aligns with the study's objective, which focuses on the relationship between empathetic nursing and inpatient satisfaction at Labuang Baji Hospital in Makassar. The characteristics of the respondents collected during the research are connected to patient perceptions of nursing services and their satisfaction levels, which include factors such as age, gender, and educational background (Karaca & Zehra, 2019).

Research carried out by (Trisnantoro, 2006) indicated that as a person ages, their demand for health services tends to rise due to an increased need for curative treatments. The researchers posit that most individuals in early adulthood can make an objective assessment while undergoing hospitalization. The findings of this study align with the view expressed by (Trisnantoro, 2006) that the higher morbidity rate among women, in comparison to men, leads to a greater need for health services, which results in women utilizing health facilities such as hospitals more frequently.

The findings from the study (Radwi, 2003) indicated that education levels have an impact on patients' views regarding the quality of nursing services. It also suggests

that individuals with higher education typically possess greater knowledge about health care and have more experiences with health services, leading to elevated expectations of these services. The researchers believe that the duration of a patient's hospital stay can influence how patients perceive and evaluate nurses' caregiving behaviors, as personal experiences in such contexts can result in varied perceptions and evaluations. Throughout their treatment, patients receive care from nurses, allowing them to both experience and assess the service as well as the nurses' conduct while delivering nursing care.

Patient satisfaction is a crucial element in assessing the quality of nursing services provided by hospital nurses. It can be evaluated through various dimensions such as tangibles, reliability, responsiveness, assurance, and empathy (Kotler, 2008).

The findings of this study align with research conducted by Trisnantoro (2006), which examined patient satisfaction's impact on nursing services in the Pangkep area's inpatient general hospital. The study revealed a correlation between patient satisfaction and nursing services, with a statistical test result of  $p = 0.002$  ( $p < \alpha$ ). Patient satisfaction is achieved when the healthcare services provided meet or exceed patients' expectations or perceptions. Understanding patient needs is essential, as it relies on their views or expectations of service providers (Rama, 2011). The researcher concludes that patient satisfaction is contingent on the services delivered by nurses; when patients' needs are addressed, they generally report being satisfied.

The link between caring nurses and patient satisfaction is an essential component in assessing the quality of nursing care provided in hospitals. The compassionate actions of nurses are closely connected to nursing services, as they nurture human relationships that improve service quality and overall patient

satisfaction. Patient satisfaction can be assessed across various dimensions, including tangibles, reliability, responsiveness, assurance, and empathy (Kotler, 2008). This is further corroborated by research on patient satisfaction in the orthopedic ward at the University of Malaysia hospital, which revealed that 82.7% of patients reported being satisfied with nursing services, highlighting respect, tranquility, gentleness, compassion, and empathy.

Research across multiple hospitals in Indonesia regarding patient satisfaction, such as the analysis of patient perceptions regarding the quality of nursing services at Muhammadiyah Temanggung, suggests a significant connection between these perceptions and inpatient satisfaction. A method to assess the quality of nursing services in hospitals is to survey patient satisfaction regarding nursing care; nurses' caring behavior can significantly influence this satisfaction.

Nurses who exhibit genuine concern in providing care for patients in hospitals are those who embody a caring attitude. According to a theory proposed by Potter et al. (2009), caring entails a nurse's sincere commitment to the patient, demonstrating empathy, gentle communication, and love, which fosters a therapeutic nurse-client relationship. As a result, the patient feels more at ease, safe, and less stressed due to their illness, thus contributing to patient satisfaction. However, in practice, there are still many nurses who do not exhibit caring behavior towards patients. Research by Shawa (2012) indicates that 90% of patients reported discomfort with nurses, while 84% experienced negative encounters due to nurses neglecting the needs of patients, particularly at night.

Kochinda (2007) indicated that patients viewed nurses' actions as compassionate when they effectively addressed their pain, provided care promptly

and within a routine, and sought to fulfill patients' needs as quickly as possible, regardless of the nature or severity of the needed care. These behaviors aligned with the essential traits of altruistic motivation to assist. Conversely, patients regarded nurses' actions as indifferent when they used complex medical jargon, delivered care on a delayed schedule or at an unsuitable time, or informed patients that they were unable to meet their needs because they were not assigned to their case during that shift. These latter behaviors corresponded with the defining characteristics of egoistic motivation to assist. Patients experienced a sense of positivity and comfort when requesting help from nurses following caring interactions. In contrast, after uncaring encounters with nurses, patients felt negative and uneasy about seeking additional assistance.

### **Nurse Caring Behaviors as Perceived by Patients**

Empirical studies indicate that the adoption of compassionate nurse behaviors enhances the patient experience; however, earlier research highlights discrepancies between how patients and nurses perceive caring. A positive patient experience correlates with favorable clinical and financial results. The caring provided by nurses is a vital element of the overall patient experience (Thomas et al., 2018). Research backs the idea that a positive patient experience is associated with improved clinical results, including reduced readmission and mortality rates. Furthermore, how patients perceive their care, especially their interactions with healthcare providers, contributes to better adherence to treatment recommendations and care plans, particularly in individuals with chronic conditions (Thomas et al., 2018).

Patient-centered care (PCC) is a crucial aim for healthcare that is becoming increasingly consumer-oriented in the United States. In 2001, the Institute of Medicine

described PCC as “delivering care that is respectful of and responsive to the unique preferences, needs, and values of each patient, and ensuring that these values guide all clinical decisions.” Donald Berwick later offered a definition that aligns with the modern movement towards enhancing patient experience: The experience (as much as the informed, individual patient desires) of transparency, individualization, acknowledgment, respect, dignity, and choice in all matters, without exception, pertaining to one’s person, circumstances, and relationships in healthcare (Thomas et al., 2018).

Caring for patients in isolation wards necessitates different approaches compared to other wards. Satisfaction with nurses’ caring behaviors significantly influences patient experiences. Enhancing patient satisfaction in isolation settings can be achieved by fostering and upholding nursing behaviors that prioritize human values, altruism, and trusting relationships, engaging in collaborative problem-solving, consistently providing supportive and corrective care, and assisting in fulfilling basic human needs (Tristiana, 2016).

11 out of 16 items on the CBI-16 displayed a mean score exceeding five, indicating that nurses regard the majority of caring behaviors as essential. Specifically, nurses placed a greater emphasis on the item “maintaining patient confidentiality,” followed by “recognizing the patient as an individual,” and “administering treatments and medications on schedule.” Previous studies that employed earlier iterations of the CBI similarly categorized these items under knowledge and skills, respect, and safety. Consequently, it appears that nurses prioritize the humanitarian aspects of care and patient safety issues. One possible explanation for this observation is that nurses feel a heightened level of responsibility toward their patients, as well as a duty to protect

personal data and dignity. These principles manifest the professional values of nursing as outlined in ethical codes. The significance that nurses place on skills and individuality in care is corroborated by researchers who argue that competence, efficiency, and safety are fundamental requisites for nursing practice (Alikari, 2022).

Nurses also consider active listening (“giving undivided attention to the patient”) and empathy (“demonstrating understanding or connection with the patient”) as among the top five most important caring behaviors. Research conducted in this field has highlighted the beneficial impact of these behaviors on effective nurse-patient communication and the fulfillment of patients’ needs. Active listening fosters an environment of mutual trust and establishes a therapeutic relationship grounded in respect for the patient’s individuality (Alikari, 2022).

### **Synthesis**

This study was based on the Theory of Human Caring developed by Dr. Jean Watson. It will be used to study how caring concepts help people gain a higher degree of harmony within the mind, body, and soul. In this study, the COVID-19 Awareness and Related Experience (C.A.R.E.) Program is the independent variable which will be applied to observe how the outcome will differ. The dependent variable is the health care workers’ anxiety level which will be the outcome that will be measured. Intervening variables are the socio-demographic characteristics such as gender, age, educational level, profession, and family structure which will be measured on how they may affect the dependent variable.

Watson’s Caring Theory states that “humans cannot be treated as objects and that humans cannot be separated from self, other, nature, and the larger workforce.”

“Her theory encompasses the whole world of nursing; with the emphasis placed on  
Effect of Watson’s CARE (COVID 19 Awareness and Related Experience) Program to 20  
Reduce Anxiety Level of Health Care Workers Isolated due to COVID 19 at Philippine Heart  
Center

the interpersonal process between the care giver and care recipient.” The theory is focused on “the centrality of human caring and on the caring-to-caring transpersonal relationship and its healing potential for both the one who is caring and the one who is being cared for”. As applied to this study, Watson’s theory of human care will hold the application of caring interventions in the care of COVID-19 patients on home isolation which aims decrease their anxiety level. During the early phase of the COVID-19 pandemic in the Philippines, psychological impact of this outbreak includes anxiety, stress levels and depression to patients (Tee et al., 2020). Patients with confirmed or suspected COVID-19 may experience fear, while those in quarantine might experience boredom, loneliness, and anger (Xiang et al., 2020). The application of ten (10) clinical caritas processes in congruent with the ten (10) carative factors in this study will meet the preconditions of Watson’s theory that in order to enable the recipient of care to experience inner harmony and healing, concrete and genuine acts of caring have to be conveyed first. Caring interventions needed for COVID-19 patients will be identified based from the clinical constructs of Watson’s theory. And then each caring interventions will be made sure that they are applied based on the ten (10) clinical caritas processes. It is said that the carative factors can alleviate anxiety and, in this study, it will be tested for the COVID-19 patients who are on isolation. The application of these carative factors were implemented from day one (1) of illness until prior clearance on going back to work.

An overview of the human caring theory suggests that caring is the "most valuable attribute" that nurses possess to serve humanity (The core concepts of Jean Watson’s Theory). According to the theorist, if patients do not receive effective care while diseases are being treated, the experience of illness will persist. Watson strongly contends that caring is the fundamental essence of nursing, without which patients'

health cannot be sustained.

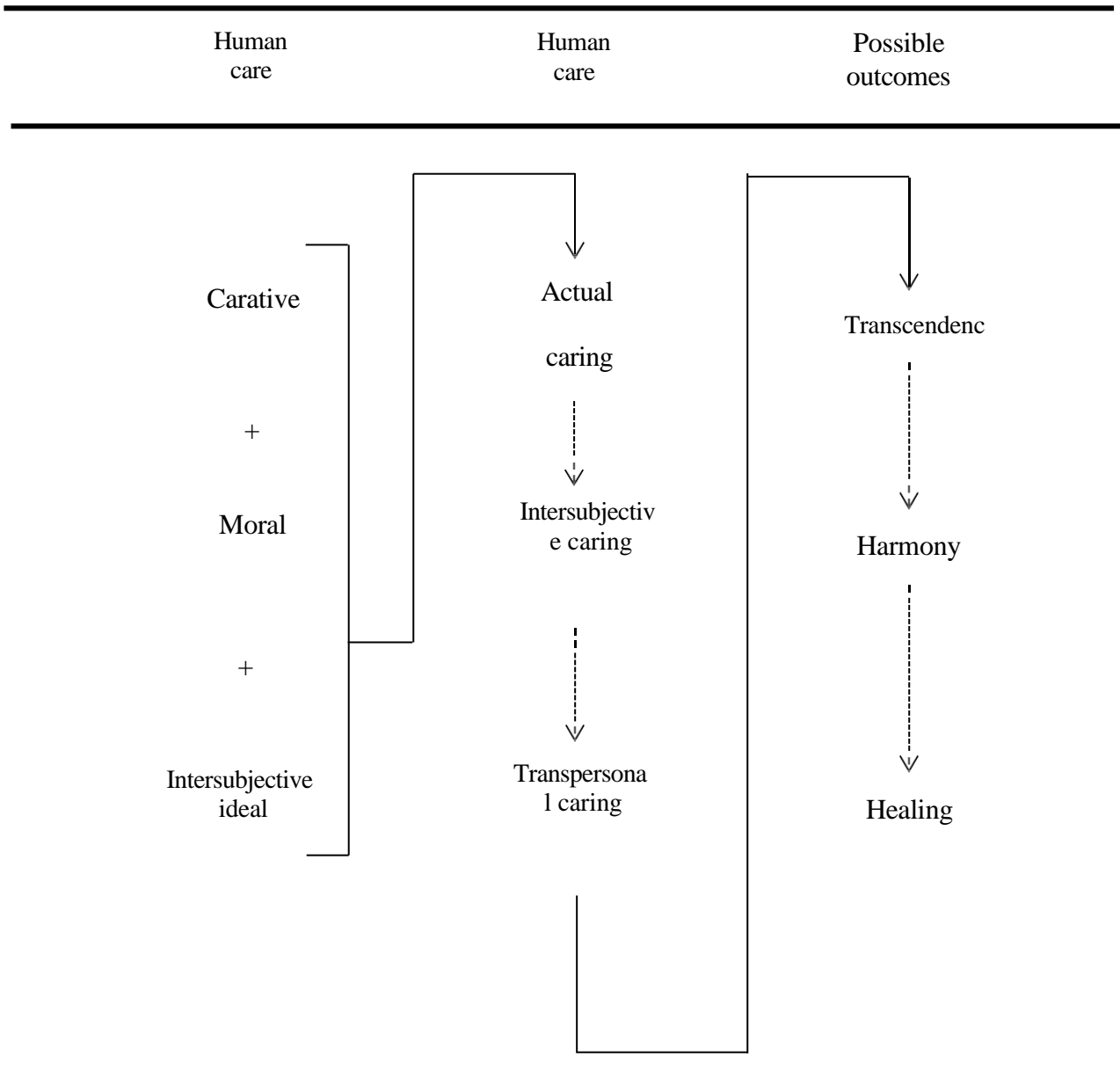
Watson identifies ten primary carative factors: Developing a humanistic-altruistic system of values; instilling faith and hope; enhancing sensitivity to oneself and others; establishing a helping-trust relationship; encouraging and accepting the expression of both positive and negative feelings; systematically applying a scientific problem-solving approach for decision-making; fostering interpersonal teaching and learning; ensuring a supportive, protective, or corrective mental, physical, socio-cultural, and spiritual environment; and assisting in the fulfillment of human needs.

This study was based on the Theory of Human Caring developed by Dr. Jean Watson. It will be used to study how caring concepts help people gain a higher degree of harmony within the mind, body, and soul. Sourial (1996) cited propositions describing Watson's Theory of Human Care. Watson developed taxonomy of interventions, or "carative factors," which according to her constitute the core of nursing when all the techniques and technologies are removed. Watson produced ten "carative factors" by structuring several concepts and principles.

Watson referred nursing as caring and describes it as an intersubjective human process, where a high value is placed upon the caring relationship between the nurse and the recipient of care. Watson's theory includes a few concepts (refer to Figure 1).

Thus, as professional nurses, both theory and practice work simultaneously. The inherent characteristics in nursing profession are nurse competency and caring abilities. To become more effective and proficient, professional nurses must adapt the principles and guidelines in nursing practice, to provide safe, effective, and quality direct patient care delivery and services to all.

Figure 1. Watson's theory of human care



The initial three elements are part of the "human care process." These consist of the carative factors, which encompass ten interventions that rely on a foundational knowledge and clinical skill set, a moral ideal that represents a commitment to protect, enhance, and preserve human dignity, and an intersubjective ideal where the nurse aims to recognize the individual significance of the care recipient. The next three concepts are termed "human care transactions," which can arise because of the

"human care process." These transactions incorporate the actual caring moment, which occurs when the nurse and the care recipient come into contact. These moments can give rise to intersubjective caring transactions. The intersubjective caring moment is where a connection forms between the personal realms of the nurse and the care recipient. This shared experience holds the potential to touch the higher spiritual essence or soul, allowing for transpersonal human caring to take place, and the transpersonal caring moment is where one's mind-body-soul interacts with another's mind-body-soul in a lived experience. In this space, a spiritual connection is established with the other individual.

By stating that "transpersonal caring is the complete realization of the carative factors in a human-to-human interaction," Watson ties her ideas of the "human care process" and "human care transactions" together. She goes on to explain that if two people can establish an intersubjective connection, the recipient is more likely to release some imbalance of the mind, body, and soul, allowing them to refocus stored energy toward their own healing journey.

In recent years, the term "carative factors" has been coined as "*clinical caritas processes*" as it evolved to its new concept which is more fluid and is align with the author's expanding direction (Watson, n.d.).

As applied to this study, Watson's theory of human care holds that the application of caring interventions in the care of patients staying in the emergency department to influence the nurse caring behaviors perceived by patients. The application of clinical caritas processes in this study meets the preconditions of Watson's theory that in order to enable the recipient of care to experience inner harmony and healing, concrete and genuine acts of caring have to be conveyed first.

## Theoretical Framework

This study is anchored on Jean Watson's Theory of Human Caring, which emphasizes the humanistic aspects of nursing combined with scientific knowledge. Watson's theory posits that caring is central to nursing practice and promotes health better than a simple medical cure. Her Ten (10) Carative Factors support the development of a therapeutic nurse-patient relationship, which is now expanded into Caritas Processes. These processes focus on holistic well-being, emotional support, and the interconnectedness of mind, body, and spirit.

In the context of the COVID-19 pandemic, healthcare workers have experienced unprecedented psychological stress, burnout, and anxiety. Watson's CARE (Covid-19 Awareness and Related Experience) Program is designed to apply the carative principles to promote self-care, emotional healing, and resilience among healthcare professionals.

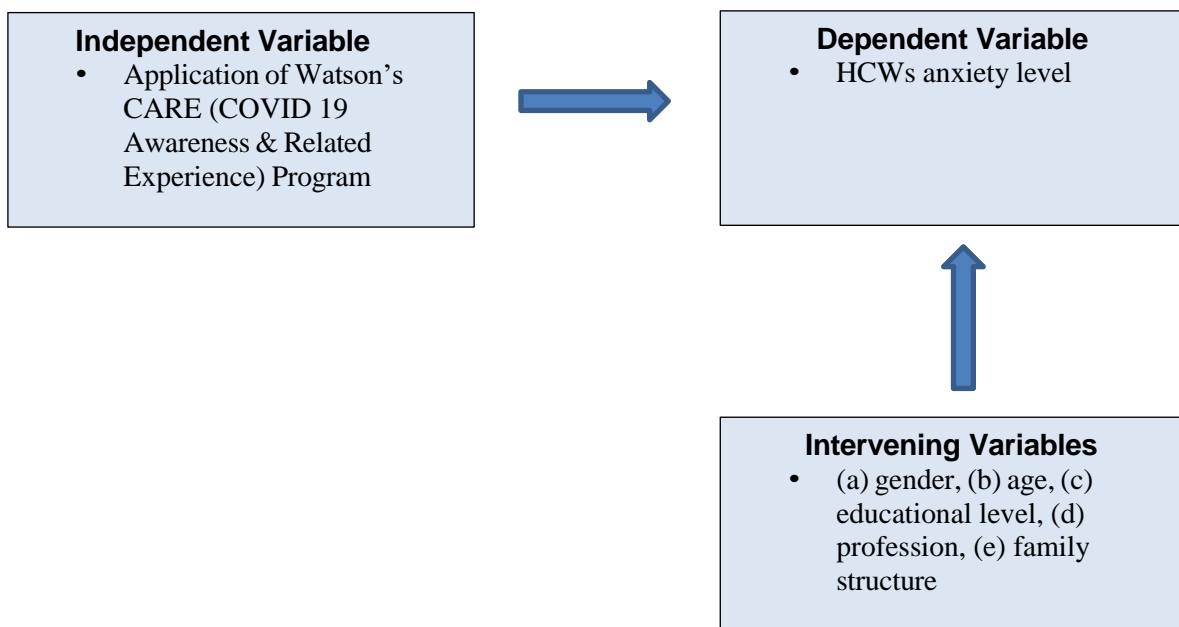
The framework suggests that through structured interventions based on Watson's Caring Science, such as reflective practice, emotional expression, mindfulness, and peer support, anxiety levels in healthcare workers can be significantly reduced. The Caring-Healing Modalities embedded in Watson's theory can help healthcare workers cope with trauma and anxiety caused by their experiences during the COVID-19 pandemic.

The input in this study is the Watson's CARE Program; the process involves its implementation among healthcare workers; and the output is the change in anxiety levels, measured before and after the intervention.

Watson's theory underpins the belief that caring environments, grounded in love, empathy, and support, facilitate healing not only for patients but also for caregivers. Thus, the theoretical foundation of this study holds that a caring-based intervention like CARE can meaningfully reduce anxiety and enhance the emotional well-being of health care workers.

### Conceptual Framework

Figure 2. Conceptual framework.



The figure above shows the relationship among the independent, dependent, and intervening variables used in this study.

The illustration above depicts the interrelationships of the variables to be addressed in this research study, where the independent variable (Implementation of Watson's C.A.R.E. – COVID-19 Awareness & Related Experience) Program is linked to the anxiety levels of healthcare workers (HCWs), which serves as the dependent

variable and is part of the intervening variables related to demographic factors: gender, age, educational attainment, profession, and family dynamics.

The conceptual framework illustrated above highlights the specific factors to be analyzed concerning the implementation of the Watson's C.A.R.E. Program and the anxiety levels of HCWs. This research study identifies two primary variables: (1) the implementation of the Watson's CARE Program as the independent variable and (2) the anxiety levels of HCWs as the dependent variable.

The socio-demographic characteristics, including gender, age, educational attainment, profession, and family dynamics, are represented with a straight line to illustrate their potential impact on the dependent variable.

### **Operational Definition of Terms**

- ***Watson's CARE (COVID-19 Awareness & Related Experience) Program*** – program designed to foster caring and interpersonal relationship on nurses and HCWs with COVID-19 who are on home isolation. It utilizes Watson's Theory of Care and derived from the Caring Protocol developed by Wolf, Bailey & Keeley (2014). It is comprised of six (6) Caring Constructs which operates from (10) Clinical Caritas Processes. It has three (3) phases: Orientation phase, Working phase and Termination phase.

Each phase in the admission care constitutes behaviors from Caring Construct one to six. Behaviors from each construct were selected based on its applicability to each phase.

- A. **Orientation Phase** – referred to the first one (1) hour of isolation of the COVID patient. This phase is directed in establishing a caring environment while identifying nursing problems.
- B. **Working Phase** – referred to the time from the start and ends after treatment has been given. The goal is to maintain the caring environment while patient is on home isolation.
- C. **Termination Phase** – started when the patient has definite plan for patient for clearance and going back to work. This phase creates a caring experience while the patient is being prepared to go back to work.
- **State-Trait Anxiety Inventory (STAI) Y1** – a psychological assessment tool comprising of 20 self-report questions on a 4-point Likert scale, designed to measure state anxiety levels.
  - **Level of Anxiety** - referred to the degree of anxiety of an individual. Anxiety refers to an emotion described by feeling of worried thoughts & tension.
  - **Demographic variables** are described as “characteristics or attributes of subjects that describe which commonly include age, educational attainment, gender, ethnicity, marital status, income, job classification, work experience, years of experience, etc.” (Grove, Gray, & Burns, 2014).
  - **Gender** defines based on self-identification, categorized as male, female, or non-binary as reported by participants.
  - **Age** indicates the total number of years a person has lived since birth.

- **Educational attainment** indicates the most advanced degree or level of education achieved.
- **Profession** refers to the current job practice in the hospital.

### **Research Hypotheses**

H<sub>0</sub>: There is no significant difference in the HCWs level of anxiety between the study group and control group.

H<sub>1</sub>: There is a significant difference in the HCWs anxiety level between the study group and control group.

H<sub>0</sub>: There is no significant difference in the HCW's level of anxiety before and after Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program.

H<sub>1</sub>: There is a significant difference in the HCW's level of anxiety before and after Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program.

H<sub>0</sub>: There is no significant relationship between HCWs anxiety level and (a) gender, (b) age, (c) educational level, (d) profession and (e) family structure.

H<sub>1</sub>: There is a significant relationship between HCWs anxiety level and (a) gender, (b) age, (c) educational level, (d) profession and (e) family structure.

## Chapter III

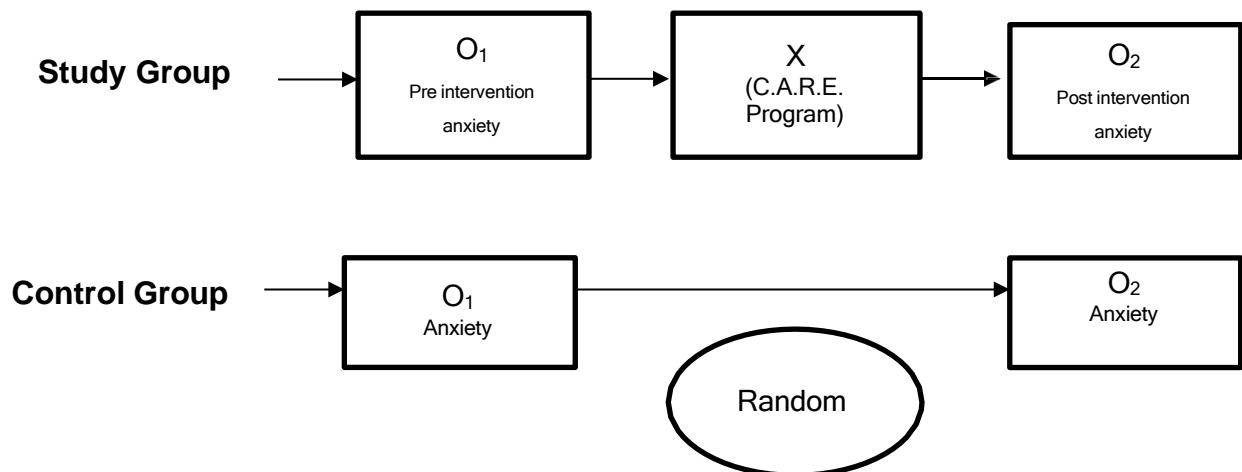
### RESEARCH METHODOLOGY

This chapter presented the research design, description of the study setting, sampling scheme, research instrument, data collection process and statistical treatment.

#### Research Design

This research employed a randomized controlled trial design, which minimizes the potential for selection bias and confounding factors. By randomly allocating participants to either the treatment or control group, it was guaranteed that the groups were similar in their characteristics and backgrounds, allowing any differences in outcomes to be attributed to the intervention.

Figure 3. Randomized Control Trial Xs and Os.



There were two groups for this research: study and control group. The study group received the Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program on health care workers who are on isolation. On the other hand,

the control group received the usual isolation protocols. Additionally, to maximize the internal validity specifically to minimize contamination, the control group was collected first, followed by the study group.

Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program was used in the study. The flow of implementation of the study was described in the appendices part of the study. The control group received routine COVID-19 isolation protocols. In the presence of a trained bedside nurse, eligibility criteria for this study will be examined. Screened patients were invited and consented to participate in the study. Conversely, the study group also registered, properly invited, and consented to participate in the study. However, these group of respondents was provided with caring interventions based on Watson's theory of caring. Both control and study group were assessed with STAI Y1 Form upon day one (1) of illness until cleared for return to work.

### **Sampling Technique**

The study population was composed of health care workers who are isolated due to COVID-19. Screening of participants was based on the following criteria:

#### *Inclusion Criteria*

- Health care workers isolated due to COVID-19
- Patients with non-urgent medical needs
- At least 19 years old
- Conscious and coherent
- Willing to participate voluntarily.

#### *Exclusion Criteria*

- Patients diagnosed with anxiety or panic attack.

- Patients with medical condition affecting memory, cognitive and physiologic function.
- Patients were medicated which alters the sensorium.
- Patients with language and comprehension barriers

### *Sample Size*

Utilizing G Power version 3.1 software, a preliminary power analysis for correlations, grounded in the point biserial model, suggested that a sample size of 64 is required, given the following parameters:

- Two-tailed test
- Medium effect size of 0.3
- Alpha level of 0.05
- Minimum power level of 80%

The sample size was determined using G Power software, applying a 95% confidence level and an 80% power level, with a moderate effect size like the study conducted by Hosseini (2023). According to the current research study and as noted by Polit & Beck (2004), a power of .80 indicates a 20% likelihood of committing a Type II error. With the specified alpha and power, it becomes possible to identify and estimate the effect of population size concerning the relationship between the variables. Although this risk may seem considerable, adopting a stricter criterion requires sample sizes that are significantly larger than what many researchers can feasibly handle. Therefore, when the relationships (effects) are strong, even small samples can reveal significant outcomes, while moderate relationships necessitate larger sample sizes to mitigate the risk of Type II errors.

While the researcher initially aimed for total of 64 participants: 32 participants for each group (study and control group) and an additional 20% has been added to the computed sample size to address possible attrition, the researcher was able to recruit 58 participants due to participant availability, time constraints and unforeseen challenges such some of the healthcare workers were not amenable to be checked and undergo swab testing despite their symptoms. Despite this limitation, adjustments were made to ensure validity of results. Although sample size was smaller than planned, the researcher ensured the reliability of results by focusing on robust data collection method such as using validated tool like STAI, ensuring consistent administration and maintaining rigorous statistical analysis. Additionally, the significant findings suggest that the trends observed in the study are still valuable and indicative of intervention's effectiveness.

### **Research Setting**

This study was conducted in the Philippine Heart Center for health care workers who has COVID-19 and on isolation, may it be on their home or in an isolation facility.

### **Data Collection**

The following steps were undertaken in the conduction of this investigation.

**Step 1:** Prepared the intervention protocol.

**Step 2:** Sought permission from the hospital administrators and research and ethics committees.

**Step 3:** Researcher coordinated with the healthcare workers with COVID-19.

**Step 4:** Eligible COVID-19 patients will be invited and consented to participate in the study.

**Step 5:** Implementation of caring interventions based on Watson's theory of human

care.

**Step 6:** Evaluation of anxiety using STAI Y1 before and after procedure.

**Table 1**

*Schedule of Activities*

<p><b>Orientation Phase</b></p> <p>First 10 minutes of registration and orientation to patient thru phone call.</p>	<p><b>DAY 1</b></p> <p><b>“Caring Construct 1 (Respectful: courteous regard for the other)”</b></p> <p>“Comforts; establishes and maintains helping/trusting relationship; respects individually.”</p> <p>1: Refer to the patient by his/her name.</p> <p>2: Provide privacy for the patient.</p> <p>3: Ensure patient’s comfort.</p> <p>4: Call the patient thru phone. Greet the patient.</p> <p>5: Explains CARE nurse’s role in his/her care that day to patient</p> <p>6: Introduce yourself to the patient by stating your name and explain nurse’s roles in his/her care.</p> <p><i>“Magandang araw po. Ako po si _____. Ako po ay ang CARE nurse niyo dito sa Philippine Heart Center.”</i></p> <p>7: Monitors patient’s status</p> <p>8: Ask the patient how he / she feels. Inquire about his/her concerns and attentively listen to what he/she says.</p>
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	<p>9: Acknowledges and helps patients express their pain, sadness, and fears.</p> <p><i>“Naiintinidihan ko po na kinababahala nyo po kung ano po ang lagay niyo”</i></p> <p>*Is available / accessible to patient.</p> <p><i>“Kung may kailangan po kayo, tawagan niyo lang po ako sa ganitong number _____. Babalik-balikan ko po kayo.”</i></p> <p>“Good morning Ms._____. I hope you are feeling better than yesterday.</p> <p>This is Jane Ivah P. Ongpauco, Unit Manager of Petal 5AB/Presidential Suite. I am seeking for your small time to invite you to participate in my research study, entitled, “Effect of Watson’s C.A.R.E Program to reduce anxiety level of Health Care Workers isolated due to COVID-19 in Philippine Heart Center.”</p> <p>Questionnaires will be sent in a google document format.</p> <p>Thank you so much in advance.</p> <p>Kindly acknowledge if received.</p>
<p><b>Working Phase</b></p> <p>Time from the start and ends after treatment has been given. The goal is to maintain the caring environment while treatment is being given.</p>	<p><b>DAY 2</b></p> <p><b>“Caring Construct 2: Knowledge and Skill: nurse caring as proficient informed and skillful”</b></p> <p>“Explains and facilitates; monitors and follows through; teaches and evaluates learning, assists with human needs, is a competent practitioner,</p>

	<p>coordinates care, provides emotional support, assist with physical, emotional and spiritual human needs.”</p> <p>1: Checks on and documents patient’s anxiety</p> <p>2: Evaluates patient’s sleep patterns</p> <p>3: Encourages patients to perform self-care</p> <p>4: Teaches patient and family by explaining procedures, treatments, treatment alternatives, medications, and rationales for intervention.</p> <p>*Perform call rounds.</p> <p><i>“Kamusta na po ang pakiramdam nyo?”</i></p> <p>5: Continuously communicate the process of care and the expected treatment to the patient. Make sure that the patient knows what to expect next, communicate realistic and liberal time expectations for the various stages in the process.</p> <p>6: Ask the patient, “do you have any questions or needs?” every time you interact with the patient.</p> <p>7: Consider the spiritual needs of the patient.</p> <p>8: When questions are asked about delays or treatment, advise the patient that you will have to check on the request.</p> <p>Good morning! Hope you feel better than yesterday. Do you still have symptoms? Did you sleep well last night?</p> <p>Sending you information on how to take care of yourself at home for your recovery. (See Figure 1)</p>
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<p style="text-align: center;"><b>Working Phase</b></p> <p>Time from the start and ends after treatment has been given. The goal is to maintain the caring environment while treatment is being given</p>	<p>*Participants concerns and questions were addressed and properly coordinated to other health team members</p>
	<p><b>DAY 3</b></p> <p><b>Caring Construct 2,3,4</b></p> <p><b>“Caring Construct 2: Knowledge and Skill: nurse caring as proficient informed and skillful”</b></p> <p>“Explains and facilitates; monitors and follows through; teaches and evaluates learning, assists with human needs, is a competent practitioner, coordinates care, provides emotional support, assist with physical, emotional and spiritual human needs”</p> <p><b>“Caring Construct 3: Connectedness: optimistic and constant readiness on part of nurse to help the other”</b></p> <p>“Operates from perspectives of humanism; instills faith and hope, accepts positive/negative expressions; provides emotional support.”</p> <p><b>“Caring Construct 4: Assurance: investment in other’s needs and security”</b></p> <p>“Supportive/protective/corrective”</p> <p>1: Checks on and documents patient’s anxiety</p> <p>2: Evaluates patient’s sleep patterns</p> <p>3: Encourages patients to perform self-care</p>

	<p>4: Teaches patient and family by explaining procedures, treatments, treatment alternatives, medications, and rationales for intervention.”</p> <p>5: Continuously communicate the process of care and the expected treatment to the patient. Make sure that the patient knows what to expect next, communicate realistic and liberal time expectations for the various stages in the process.</p> <p>6: Ask the patient, “do you have any questions or needs?” every time you interact with the patient.</p> <p>7: Consider the spiritual needs of the patient.</p> <p>8: When questions are asked about delays or treatment, advise the patient that you will have to check on the request.</p> <p>9: Is accessible/available to patient and family</p> <p>10: Is hopeful and cheerful with patient</p> <p>11: Asked patient if he/she has any needs</p> <p>12: Encouraged patient to express feelings about his/her disease</p> <p>13: Encourages patient to express his/her feelings, beliefs, concerns and positive and negative feelings</p> <p>14: Is available to patient and family to focus on his/her concerns</p> <p>15: Pays attention and responds to patients cues</p> <p>16: Attempts to calm patients fears</p>
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	<p><i>“Good morning! Hope you feel better than yesterday. How are you po? Were you able to sleep well last night? Do you still have symptoms?”</i></p> <p><i>“Will continue to pray for your recovery.”</i></p> <p><i>“You will be asked to go on infirmary clearance on ___ and be back to work one cleared.”</i></p> <p><i>“If you need help or do you have any questions at hand. Do not forget to message me. Thank you!”</i></p> <p><i>“Thank you for sharing that with me. It’s completely natural to feel this way, especially your present condition. Would it help if we talked about what you’re feeling or would you prefer a few quiet moments?”</i></p> <p>*Participants concerns and questions were addressed and properly coordinated to other health team members</p>
<p><b>Termination Phase</b></p> <p>Starts when there is a definite plan for patient for clearance. This phase creates a caring experience while the patient is being prepared to go back to work.</p>	<p><b>DAY 4</b></p> <p><b>Caring Construct 2,3,4</b></p> <p><b>“Caring Construct 2: Knowledge and Skill: nurse caring as proficient informed and skillful”</b></p> <p>“Explains and facilitates; monitors and follows through; teaches and evaluates learning, assists with human needs, is a competent practitioner, coordinates care, provides emotional support, assist with physical, emotional and spiritual human needs”</p>

	<p><b>“Caring Construct 3: Connectedness: optimistic and constant readiness on part of nurse to help the other</b></p> <p>Operates from perspectives of humanism; instills faith and hope, accepts positive/negative expressions; provides emotional support”</p> <p><b>“Caring Construct 4: Assurance: investment in other’s needs and security”</b></p> <p>“Supportive/protective/corrective”</p> <p>1: Checks on and documents patient’s anxiety</p> <p>2: Evaluates patient’s sleep patterns</p> <p>3: Encourages patients to perform self-care</p> <p>4: Teaches patient and family by explaining procedures, treatments, treatment alternatives, medications and rationales for intervention.</p> <p>5: Continuously communicate the process of care and the expected treatment to the patient. Make sure that the patient knows what to expect next, communicate realistic and liberal time expectations for the various stages in the process.</p> <p>6: Ask the patient, “do you have any questions or needs” every time you interact with the patient.</p> <p>7: Consider the spiritual needs of the patient.</p> <p>8: When questions are asked about delays or treatment, advise the patient that you will have to check on the request.</p>
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<p style="text-align: center;"><b>Termination Phase</b></p> <p>Starts when there is a definite plan for patient for clearance.</p> <p>This phase creates a caring experience while the patient is</p>	<p>9: Is accessible/available to patient and family.</p> <p>10: Is hopeful and cheerful with patient.</p> <p>11: Asked patient if he/she has any needs.</p> <p>12: Encouraged patient to express feelings about his/her disease.</p> <p>13: Encourages patient to express his/her feelings, beliefs, concerns and positive and negative feelings.</p> <p>14: Is available to patient and family to focus on his/her concerns.</p> <p>15: Pays attention and responds to patients cues.</p> <p>16: Attempts to calm patients fears.</p> <p><i>“Good morning! Hope you feel better than yesterday. How are you po? Were you able to sleep well last night? Do you still have symptoms?”</i></p> <p><i>“Tomorrow is your clearance day, let me know if you are cleared of going back to work 🍷”</i></p> <p><i>“Will continue to pray for your recovery. 🙏”</i></p> <p><i>“If you need help or do you have any questions at hand. Do not forget to message me. Thank you!”</i></p> <p>*Participants concerns and questions were addressed and properly coordinated to other health team members</p>
	<p style="text-align: center;"><b>DAY 5</b></p>

being prepared to go back to work.

**Caring Construct 5,6**

**“Caring Construct 5: Attentiveness: appreciation of and engrossment in the other’s perspective and experience”**

“Accessible, anticipates patient’s needs, respects cultural practices, beliefs and needs.”

**“Caring Construct 6: Collaboration: engagement in collegial, interdependent partnership**

Cooperative; interdisciplinary shared planning, open coordination and communication, shares decision making and goal setting”

1: Supports beliefs and values.

2: Pay attention to patient healing.

3: Anticipates patient’s needs and concerns.

4: Inform the patient of the progress of his / her care; what he / she expects; provide health teachings as necessary.

5: Extends community caring to other department/services.

6: Communicates effectively with physicians and other services.

7: Follows through with prioritized plan of care.

8: Impart words of hope as the patient is cleared for work.

	<p>“Good morning! Hope you feel better than yesterday. How are you po?”</p> <p>“Today is your clearance day, kindly proceed to infirmary /ER”</p> <p>“Let me know if you are cleared for going back to work.”</p> <p>Here are measures you can do in preventing to acquire the disease again:</p> <p>&amp; Clean your home regularly, particularly frequently touched surfaces</p> <p>&amp; Stay physically fit. Exercise Regularly. Eat a nutritious diet.</p> <p>&amp; Wash your hands regularly.</p> <p>&amp; Stay positive. Be connected to friends and families.</p> <p><i>“Will continue to pray for your recovery.”</i></p> <p><i>“If you need help or do you have any questions at hand. Do not forget to message me. Thank you!”</i>”</p>
	<p><b>DAY 6</b></p> <p>Good morning! I am glad you are cleared for going back to work.</p> <p>Attached is a short questionnaire after your COVID 19 recovery. Your participation is highly encouraged.</p>

	If you need help or do you have any questions at hand. Do not forget to message me. Thank you!
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Figure 4. Information sent to participants on Day 2.



### Research Instruments

The study utilized the following:

#### ***Patient Data Profiling***

This instrument was obtained from both experimental and control groups. The patient’s personal information was coded in a logbook which served as primary tool for referencing.

#### ***Watson’s CARE (COVID 19 Awareness & Related Experience) Program***

This referred to the care to COVID-19 patients who are isolated. This utilized Watson's Theory of Care. It has three (3) phases: Orientation phase, Working Phase and Termination Phase.

### ***State-Trait Anxiety Inventory Scale (STAI Y1) Form for the pretest and post-test***

This 20-item self-assessment tool is a psychological inventory based on a 4-point Likert scale that measured current anxiety of the patient.

### **Plan for Data Analysis**

This study aimed to determine the effectiveness of Watson's COVID-19 Awareness and Related Experience (C.A.R.E.) Program in reducing the anxiety levels of healthcare workers on isolation. The data analysis plan involved both descriptive and inferential statistics, using a pre-test and post-test control group design.

#### **1. Data Preparation**

- Collected data from both control and intervention groups were encoded in Microsoft Excel and analyzed using STATA 13.1.
- Scores from the State-Trait Anxiety Inventory (STAI-Y1) were computed based on standardized scoring guidelines.
- All data will be anonymized to maintain confidentiality.

#### **2. Descriptive Statistics**

- Frequency and percentage were used to describe the categorical variables (e.g., gender, profession, family structure).
- Mean and standard deviation were computed for continuous variables (e.g., age, STAI scores).

#### **3. Testing for Normality**

- Shapiro-Wilk test were used to assess the normality of continuous data (e.g., pre-test and post-test anxiety scores).
- Histograms and Q-Q plots were utilized for visual assessment if necessary.

#### **4. Inferential Statistics**

##### **a. Comparison Between Groups (Study vs Control)**

Independent samples t-test: Used to compare mean anxiety levels between the study and control groups, both pre-test and post-test.

- If data are not normally distributed, the Mann-Whitney U test was used as a non-parametric alternative.

##### **b. Within-Group Comparisons (Pre-test vs Post-test)**

- Paired t-test: Used to assess differences in anxiety scores before and after the intervention within the same group (study group).
- If normality is violated, the Wilcoxon Signed-Rank test was used.

##### **c. Association with Demographic Variables**

- Chi-square test (or Fisher's exact test when appropriate): Used to assess the relationship between categorical variables (e.g., gender, profession) and anxiety level classifications.
- Independent t-test or ANOVA: To compare mean anxiety levels across demographic groups (e.g., age groups, educational attainment).

#### **5. Significance Level**

- A p-value < 0.05 was considered statistically significant.
- All statistical tests was two-tailed.

#### **6. Software**

- Data analysis was carried out using STATA 13.1 and Microsoft Excel for data management.

## **Data Management**

All collected data were saved on a password-protected laptop that only the researcher had access to. This was also encoded in Excel sheet before asking for help to a certified statistician who ran the data in SPSS. Backup copies were kept on encrypted external storage to prevent data loss. Physical papers, such as request letters and other forms, were safely preserved in a locked cabinet. The data were only utilized for this study and will be kept for five years before being safely disposed of in compliance with institutional data retention policy.

## **Statistical Treatment**

The following statistical treatment were applied in analyzing data collected in this study. Descriptive statistics was used to determine the frequency and percentage of the participant's profile in terms of age, gender, educational level, profession, and family structure. It showed no significant differences in demographic and baseline anxiety measures between the study and control groups, confirming that the two groups were well-matched at the start of the study.

To ensure that the groups were comparable on key characteristics like age, gender, and educational level, independent t-tests and Chi-square/Fisher's exact tests were used. Independent T-test was used to determine the difference between the study and comparison group in terms of their caring behaviors. Chi-square test was used to test the association of nominal variables such as sex, and educational level and anxiety. These tests confirmed that there were no significant differences between the groups on these factors, which means any changes in anxiety levels could more confidently be attributed to the intervention.

The paired t-tests revealed significant improvements in anxiety measures for

the study group, particularly in areas like jitteriness, nervousness, and overall anxiety scores. This suggests that the intervention had a real, positive impact on managing anxiety.

Finally, normality tests (Shapiro-Wilk) confirmed that the data for continuous variables followed a normal distribution, justifying the use of parametric tests like t-tests. This ensures that the statistical methods used in the analysis were appropriate for the data and that the findings are robust.

### **Ethical Considerations**

Ethical considerations were upheld throughout this study. Approval was obtained from the hospital's ethics committee. Authorization to utilize instruments and concepts was received from the respective authors. Efforts were coordinated and properly directed to foster a constructive professional relationship with nurse managers and staff nurses. In conducting this study, the researcher made sure to engage with participants on a personal level, ensuring their privacy was respected and not intruded upon without their consent, and that the research did not cause them any emotional distress, while also ensuring all information gathered was duly acknowledged and accurately portrayed.

Ethical considerations were ensured in this study:

#### ***Privacy and Confidentiality:***

- Confirmed that the information provided would remain unidentifiable to anyone except the researcher.
- Made certain that participants were aware that any information derived from the study used in presentations or reports would have all identifying details altered to preserve privacy and confidentiality.

- Assured that participants were clearly informed that the findings would be included in the thesis.
- Clarified that participants understood the thesis might be examined by future nursing students in the course.

***Safety/Non-Maleficence:***

- Removed all potential risk factors.
- Guaranteed that safety will remain stable over time.
- Verified that the research poses no harm to participants and affirms appropriate handling of information.

***Autonomy/Beneficence:***

- The researcher guaranteed that participation is entirely voluntary and that individuals can withdraw from the study at any point. At that time, no additional data will be collected or analyzed, and all previously gathered data will be deleted.
- Questionnaires that were not submitted and participants who chose not to participate in the project were excluded from the research.
- There was no pressure or influence exerted on the participants' decision-making that conflicted with their values.

***Dignity:***

- Every participant had the autonomy to make their own well-informed choices.
- All participants were treated with utmost respect.

***Informed Consent:***

- Every participant was provided with a consent letter outlining important aspects of the study and detailing what is required from both them and the researcher. A consent form accompanied the letter, which participants signed if they

consented to participate and comprehended their role in the research.

### ***Threats to Internal Validity***

In conducting this research, potential threats to internal validity were recognized and addressed to ensure study's outcomes are genuinely attributable to the intervention rather than extraneous factors. Here are the following threats and mitigation:

1. **History:** External events occurring during the study period, such as changes in hospital policies or the progression of the COVID-19 pandemic, could influence participants' anxiety levels independently of the intervention. In this study, a control group was implemented who does not receive the intervention to differentiate the effects of the CARE Program from external events.
2. **Maturation:** Participants may experience natural changes over time, such as increased resilience or adaptation to isolation, which could affect anxiety levels regardless of the intervention. In this study, the use of a control group was implemented to account for natural changes over time. It was ensured that both the intervention and control groups were assessed simultaneously to control for maturation effects.
3. **Instrumentation:** Changes in measurement tools or procedures, such as switching assessment instruments or altering data collection methods, could impact the consistency and reliability of the results. In this study, there was a consistency in the measurement instruments and data collection procedures throughout the study.
4. **Selection Bias:** If participants are not randomly assigned to intervention and control groups, pre-existing differences between these groups could influence the outcomes, making it difficult to attribute changes solely to the CARE

Program. In this study, random assignment of participants were employed to create equivalent groups.

5. **Compensatory Rivalry:** Control group participants might alter their behavior upon learning they are not receiving the intervention which can affect the study outcomes. In this study, participants were blinded to their group assignments to ensure that both groups receive attention and support to minimize feelings of neglect or competition.

## Chapter IV

### RESULTS AND DISCUSSIONS

#### Results

Descriptive statistics were applied to summarize the demographic and clinical features of the patients. Categorical variables were analyzed using frequency and proportion, while normally distributed continuous variables were assessed using mean and standard deviation. The differences in mean and frequency between the patient study group and the control group were evaluated using the independent sample T-test and Fisher's exact/Chi-square test. Paired Sample T-tests were conducted to evaluate the mean difference in the responses of the Pretest to Post-test STAI Form Y-1 Questionnaire. All statistical tests were performed as two-tailed tests. The Shapiro-Wilk test was utilized to assess the normality of the continuous variables. Missing values were neither substituted nor estimated. Null hypotheses were rejected at a significance level of 0.05 $\alpha$ . Data management and analysis were carried out using Microsoft Excel and STATA 13.1.

#### Demographic Profile of the Patients

**Table 2**

*Demographic profile of the patients*

	<b>Total (n=58)</b>	<b>Study group (n=29)</b>	<b>Control group (n=29)</b>	<b>P- value</b>
	<b>Frequency (%); Mean <math>\pm</math> SD</b>			
Age, years	33.81 $\pm$ 7.05	34.03 $\pm$ 7.48	33.59 $\pm$ 6.71	0.811
Sex				0.773

Male	17 (29.31)	8 (27.59)	9 (31.03)	
Female	41 (70.69)	21 (72.41)	20 (68.97)	
Educational attainment				0.221
College	55 (94.83)	28 (96.55)	27 (93.1)	
Master's Degree	1 (1.72)	1 (3.45)	0	
Doctorate	2 (3.45)	0	2 (6.9)	
Employment Status				-
Full Time	58 (100)	29 (100)	29 (100)	
Family Structure				0.330
Parents and children	21 (36.21)	9 (31.03)	12 (41.38)	
Lives alone	4 (6.9)	2 (6.9)	2 (6.9)	
Parents, children, grandchildren	3 (5.17)	3 (10.34)	0	
Others	30 (51.72)	15 (51.72)	15 (51.72)	

The table summarizes the demographic profile of 58 healthcare workers, divided equally into a study group (n=29) and a control group (n=29). The mean age is comparable across groups: Study group: 34.03 ± 7.48 years and Control group: 33.59 ± 6.71 years. The P-value of 0.811 indicates no significant difference in age distribution, suggesting that both groups are age-matched. According to sex, female participants dominate in both groups: Study group: 72.41% and Control group: 68.97% while Male participants are 27.59% (study) and 31.03% (control). The P-value of 0.773 shows no significant difference in gender distribution. With regards to educational attainment, most participants (94.83%) hold a college degree. Only a few participants have advanced degrees (master's or Doctorate). The study group has one individual with a master's degree (3.45%), while the control group has two with a Doctorate

(6.9%). The P-value of 0.221 implies no significant difference in education levels. According to employment status, all participants are employed full-time (100%). This uniformity ensures the comparison focuses on other variables, such as program impact. According to family structure, Family dynamics are categorized as *Parents and children*: 31.03% (study) vs. 41.38% (control), *Lives alone*: 6.9% in both groups and *Parents, children, grandchildren*, and *Others* are sparsely distributed. A P-value of 0.330 indicates no significant difference in family structure.

The data indicate that participants were well-balanced between the study and control groups across all variables, including age, gender, educational attainment, employment status, and family structure. The absence of significant differences ( $p > 0.05$ ) suggests that these variables did not bias the intervention outcomes. Notably, all participants were employed full-time, which may indicate a potentially higher baseline anxiety level due to work-related stress during the pandemic. The balance between groups strengthens the study's internal validity, as any observed effects on anxiety can be attributed more confidently to the C.A.R.E. program.

**Table 3**

*Pre-test STAI Form Y-1 Questionnaire responses*

	Total (n=58) Mean $\pm$ SD	Study group (n=29)	Control group (n=29)	P- value
1. I feel calm	3.31 $\pm$ 0.60	3.24 $\pm$ 0.64	3.38 $\pm$ 0.56	0.385
2. I feel secure	3.40 $\pm$ 0.59	3.34 $\pm$ 0.61	3.45 $\pm$ 0.57	0.510
3. I am tense	1.91 $\pm$ 1.03	1.83 $\pm$ 0.97	2 $\pm$ 1.10	0.529
4. I feel stained	1.19 $\pm$ 0.54	1.27 $\pm$ 0.65	1.10 $\pm$ 0.41	0.231

5. I feel at ease	2.69 ± 0.60	2.62 ± 0.62	2.76 ± 0.58	0.385
6. I feel upset	1.67 ± 0.82	1.90 ± 0.94	1.45 ± 0.63	0.037
7. I am presently worrying over possible misfortunes	2.34 ± 1.19	2.24 ± 1.12	2.45 ± 1.27	0.514
8. I feel satisfied	2.95 ± 0.63	2.96 ± 0.68	2.93 ± 0.59	0.838
9. I feel frightened	1.64 ± 0.74	1.66 ± 0.77	1.62 ± 0.73	0.861
10. I feel comfortable	2.79 ± 0.72	2.83 ± 0.71	2.76 ± 0.74	0.719
11. I feel self-confident	3.43 ± 0.50	3.41 ± 0.50	3.45 ± 0.51	0.795
12. I feel nervous	2.31 ± 0.94	2.24 ± 0.95	2.38 ± 0.94	0.581
13. I am jittery	2.55 ± 0.92	2.38 ± 0.98	2.72 ± 0.84	0.156
14. I feel indecisive	2.53 ± 0.96	2.38 ± 0.98	2.69 ± 0.93	0.221
15. I am relaxed	3.26 ± 0.61	3.21 ± 0.62	3.31 ± 0.60	0.522
16. I feel confident	3.5 ± 0.50	3.41 ± 0.50	3.59 ± 0.50	0.196
17. I am worried	2.38 ± 0.88	2.27 ± 0.96	2.48 ± 0.78	0.373
18. I feel confused	2.07 ± 0.93	2.24 ± 0.95	1.90 ± 0.90	0.162
19. I feel steady	3.02 ± 0.44	3.07 ± 0.46	2.97 ± 0.42	0.374
20. I feel pleasant	2.79 ± 0.52	2.72 ± 0.65	2.86 ± 0.35	0.318
Total Pre-test STAI Form Y-1 score	2.58 ± 0.21	2.56 ± 0.24	2.61 ± 0.19	0.379

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Pre intervention, participants completed the **pre-test STAI Form Y-1**, which provided a baseline measure of their anxiety levels. The results from this pre-test revealed that, overall, both the study and control groups had similar levels of anxiety, with no significant differences found for most individual items or the overall total score ( $p > 0.05$ ). This suggests that, before the intervention, both groups were experiencing

comparable levels of anxiety, which is important for accurately evaluating the effects of the intervention.

Looking at specific anxiety indicators, there were some notable observations. For instance, items like "I feel calm" ( $p=0.385$ ) and "I feel secure" ( $p=0.510$ ) showed no significant differences between the two groups, indicating that participants in both groups reported relatively stable emotional states at baseline. This suggests that neither group was experiencing extreme anxiety at the outset of the study, and both were relatively balanced in terms of general emotional well-being.

However, one item stood out with a significant difference: "I feel upset" ( $p=0.037$ ). The study group reported slightly higher levels of upset feelings compared to the control group. This could indicate that the participants in the study group were feeling more stressed or unsettled pre intervention, potentially suggesting a greater baseline need for the intervention, which may have targeted emotional regulation or stress management.

Finally, when looking at the total pre-test STAI score, there was no significant difference between the two groups (study group: 2.56, control group: 2.61,  $p=0.379$ ), reinforcing the conclusion that both groups began with comparable levels of anxiety. This lack of significant difference in overall anxiety levels ensures that any changes observed later could be attributed to the effects of the intervention, rather than pre-existing differences between the groups.

In summary, the pre-test results show that both the study and control groups had similar anxiety levels at baseline. While there were minor differences in some individual items (such as feeling upset), these differences were not large enough to bias the study's outcomes. This solid baseline provides a fair starting point for

assessing the impact of the C.A.R.E. program on reducing anxiety over the course of the intervention.

**Table 4**

*Post-test STAI Form Y-1 Questionnaire responses*

	Total (n=58) Mean $\pm$ SD	Study group (n=29)	Control group (n=29)	P- value
1. I feel calm	3.36 $\pm$ 0.48	3.34 $\pm$ 0.48	3.38 $\pm$ 0.49	0.789
2. I feel secure	3.33 $\pm$ 0.47	3.21 $\pm$ 0.41	3.45 $\pm$ 0.51	0.051
3. I am tense	2.29 $\pm$ 1.15	2.55 $\pm$ 1.18	2.03 $\pm$ 1.08	0.088
4. I feel stained	1.1 $\pm$ 0.36	1.14 $\pm$ 0.35	1.07 $\pm$ 0.37	0.470
5. I feel at ease	2.69 $\pm$ 0.71	2.83 $\pm$ 0.80	2.55 $\pm$ 0.57	0.138
6. I feel upset	1.57 $\pm$ 0.77	1.69 $\pm$ 0.89	1.45 $\pm$ 0.63	0.239
7. I am presently worrying over possible misfortunes	2.10 $\pm$ 1.16	1.69 $\pm$ 0.85	2.52 $\pm$ 1.30	0.006
8. I feel satisfied	3 $\pm$ 0.50	3.03 $\pm$ 0.42	2.97 $\pm$ 0.57	0.601
9. I feel frightened	1.62 $\pm$ 0.74	1.62 $\pm$ 0.78	1.62 $\pm$ 0.73	1.000
10. I feel comfortable	2.79 $\pm$ 0.64	2.86 $\pm$ 0.58	2.72 $\pm$ 0.70	0.418
11. I feel self-confident	3.22 $\pm$ 0.70	3.03 $\pm$ 0.82	3.41 $\pm$ 0.50	0.038
12. I feel nervous	1.98 $\pm$ 0.99	1.66 $\pm$ 0.94	2.31 $\pm$ 0.97	0.011
13. I am jittery	2.17 $\pm$ 1.01	1.72 $\pm$ 0.96	2.62 $\pm$ 0.86	<0.001
14. I feel indecisive	2.26 $\pm$ 1.07	1.90 $\pm$ 1.05	2.62 $\pm$ 0.98	0.008
15. I am relaxed	3.19 $\pm$ 0.51	3 $\pm$ 0.38	3.38 $\pm$ 0.56	0.004
16. I feel confident	3.24 $\pm$ 0.80	2.97 $\pm$ 0.94	3.52 $\pm$ 0.51	0.008

17. I am worried	2.12 ± 0.94	1.83 ± 1.00	2.41 ± 0.78	0.016
18. I feel confused	1.86 ± 0.94	1.76 ± 0.99	1.97 ± 0.91	0.409
19. I feel steady	3.09 ± 0.51	3.17 ± 0.54	3 ± 0.46	0.197
20. I feel pleasant	2.97 ± 0.32	3.07 ± 0.26	2.86 ± 0.35	0.013
Total Post-test STAI Form Y-1 score	2.50 ± 0.19	2.40 ± 0.19	2.59 ± 0.15	<0.001

Post intervention, the post-test results from the STAI questionnaire revealed significant improvements in anxiety measures for the **study group**, particularly in areas related to self-confidence, nervousness, and physical manifestations of anxiety. These improvements were not seen in the **control group**, highlighting the effectiveness of the C.A.R.E. program.

One of the most notable findings was an increase in self-confidence ( $p=0.038$ ) and a decrease in nervousness ( $p=0.011$ ) for the study group. These changes suggest that the intervention helped participants feel more assured and less anxious in situations that might have triggered nervousness or uncertainty. In contrast, the control group did not show any significant changes in these areas, indicating that these improvements were likely due to the program itself rather than external factors.

Another key improvement in the study group was the significant reduction in jitteriness ( $p<0.001$ ), a physical symptom commonly associated with anxiety. This reduction suggests that the C.A.R.E. program was effective not only in managing emotional states but also in helping participants address the physical manifestations of stress, which can often be more difficult to control.

The study group also showed significant reductions in worrying ( $p=0.006$ ) and

indecisiveness ( $p=0.008$ ), two other common indicators of anxiety. These findings suggest that the program helped participants gain greater clarity and reduce the tendency to overthink or become paralyzed by uncertainty. Again, the control group did not demonstrate significant changes in these areas, further supporting the notion that the improvements were a direct result of the intervention.

Finally, when looking at the total anxiety score, the study group showed a marked reduction ( $p<0.001$ ), indicating an overall decrease in anxiety levels following the intervention. While the control group also showed a slight improvement, it was not statistically significant, underscoring that the changes in the study group were more pronounced and likely attributable to the intervention.

In summary, the post-test results clearly demonstrate that the C.A.R.E. program had a significant positive impact on reducing anxiety. Participants in the study group showed improvements across multiple dimensions of anxiety, including emotional states like self-confidence and nervousness, as well as physical symptoms like jitteriness. These findings strongly suggest that the program was effective in alleviating anxiety and providing participants with tools to manage stress more effectively.

**Table 5**

*Comparison from Pre-test to Post-test STAI Form Y-1 Questionnaire responses*

	Total (n=58)	Study group (n=29)	Control group (n=29)
	P-value		
1. I feel calm	0.168	0.161	0.663

2. I feel secure	0.289	0.161	1.000
3. I am tense	0.005	0.006	0.326
4. I feel stained	0.133	0.212	0.326
5. I feel at ease	1.000	0.264	0.056
6. I feel upset	0.182	0.083	1.000
7. I am presently worrying over possible misfortunes	0.114	0.004	0.769
8. I feel satisfied	0.553	0.573	0.787
9. I feel frightened	0.829	0.326	1.000
10. I feel comfortable	1.000	0.663	0.713
11. I feel self-confident	0.027	0.032	0.573
12. I feel nervous	0.004	0.002	0.573
13. I am jittery	0.002	0.002	0.415
14. I feel indecisive	0.005	0.006	0.424
15. I am relaxed	0.289	0.031	0.424
16. I feel confident	0.008	0.017	0.161
17. I am worried	0.002	0.005	0.161
18. I feel confused	0.044	0.004	0.537
19. I feel steady	0.103	0.083	0.573
20. I feel pleasant	0.017	0.016	1.000
Total STAI Form Y-1 score	<0.001	<0.001	0.517

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The within-group comparisons using paired sample t-tests provided a deeper look into how the intervention impacted anxiety levels over time. For the study group, there were significant improvements across several key anxiety indicators, highlighting the

effectiveness of the C.A.R.E. program in reducing anxiety.

First, there were marked reductions in the physical and emotional symptoms of anxiety. The study group showed significant decreases in tension ( $p=0.005$ ), nervousness ( $p=0.004$ ), and jitteriness ( $p=0.002$ ). These reductions suggest that the intervention successfully addressed both the emotional and physical aspects of anxiety, helping participants feel less tense and jittery, and more in control of their emotional responses. Such changes are important because they reflect the program's ability to reduce both the psychological and physiological symptoms of stress.

Additionally, the study group experienced a significant improvement in self-confidence ( $p=0.027$ ), further reinforcing the positive impact of the intervention on emotional regulation. Increased self-confidence is a key outcome, as it helps individuals feel more resilient in the face of stressors and better able to manage anxiety-provoking situations.

In contrast, the control group did not show significant improvements in these same areas. The lack of changes in anxiety symptoms among the control group suggests that the reductions in anxiety seen in the study group were likely due to the intervention rather than natural changes over time.

When looking at the total anxiety score, the study group experienced a significant reduction ( $p<0.001$ ), meaning that their overall anxiety levels decreased after the intervention. This decrease in the total score highlights the overall effectiveness of the C.A.R.E. program in reducing anxiety. On the other hand, the control group showed no significant change in their total anxiety score ( $p=0.517$ ), which further supports the conclusion that the observed improvements in the study group were specifically linked to the intervention.

The tables collectively illustrate the effectiveness of the C.A.R.E. program in reducing anxiety among healthcare workers in isolation. The balanced baseline characteristics (Table 1) ensure unbiased intervention outcomes. The lack of significant differences in pre-test anxiety (Table 2) provides a fair starting point for comparison. Post-intervention improvements in the study group (Table 3) and substantial reductions in anxiety from the pre-test to the post-test (Table 4) demonstrate the program's success in mitigating stress and promoting emotional well-being.

In PHC, existing policies such as healthcare workers with COVID-19 are isolated for five (5) days to minimize transfer of infection of which the study has been applied. In aligning the study's findings with Jean Watson's Theory of Human Caring, it was observed that the implementation of the CARE Program has effectively reduced anxiety levels among healthcare workers isolated due to COVID-19 at the Philippine Heart Center (PHC). This outcome underscores the practical application of Watson's carative factors, particularly in fostering a supportive and empathetic environment.

The CARE Program's emphasis on creating a healing environment and developing authentic, trusting relationships resonates with Watson's carative factors, such as the cultivation of sensitivity to oneself and others, and the development of helping-trusting relationships. These elements have been instrumental in addressing the psychological needs of isolated healthcare workers, thereby mitigating their anxiety.

This correlation between the CARE Program's outcomes and Watson's theoretical framework highlights the significance of holistic, compassionate care in promoting mental well-being among healthcare professionals during periods of

isolation.

The findings are consistent with the previous research that has applied Watson's Theory in educational settings. For instance, a randomized controlled trial by Durgun Ozan and Diman (2020) examined the effects of a clinical education program based on Watson's theory on nursing students' coping and anxiety levels. The study found that students in the intervention group exhibited significant improvements in anxiety and coping strategies compared to the control group.

Similarly, this study demonstrates that interventions grounded in Watson's caring principles can effectively reduce anxiety among healthcare workers in isolation. BY fostering a caring-healing environment and emphasizing authentic, trusting relationships, the CARE Program addresses the psychological needs of healthcare workers, thereby mitigating anxiety and promoting overall well-being. This correlation highlights the value of integrating caring science into organizational practices to enhance the mental health and resilience of healthcare professionals.

## Chapter V

### CONCLUSION AND RECOMMENDATIONS

#### Conclusions

Overall, the study concludes the effectiveness of the intervention as the study demonstrated a statistically significant reduction of the level of anxiety among healthcare workers in the study group who participated in Watson's COVID-19 awareness and related experience program. Specifically, the results conclude:

1. After the intervention, the total anxiety scores of the study group showed a significant reduction ( $p < 0.001$ ) when compared to their scores prior to the intervention. Conversely, the control group did not exhibit any significant change ( $p = 0.379$ ).
2. In the comparison between study and groups, the study group's post-test anxiety scores ( $2.40 \pm 0.19$ ) were significantly lower than those of the control group ( $2.59 \pm 0.15$ ,  $P < 0.001$ ), indicating that the program was effective in reducing anxiety compared to no intervention.
3. In the specific emotional improvements, the intervention led to significant improvements in participants' feelings of calmness, security, satisfaction, self-confidence, and overall emotional well-being ( $P < 0.05$  for several questionnaire items). These findings suggest that the program addressed not only general anxiety but also specific emotional states, enhancing the participants' psychological resilience during isolation.
4. In the relevance to healthcare workers in isolation, given the increased psychological burden on healthcare workers during isolation, Watson's program provided essential mental health support by fostering emotional

stability and reducing anxiety. This outcome underscores the importance of targeted psychological interventions for frontline workers during pandemics or similar crises.

5. Implementing structured programs like Watson's C.A.R.E. Program initiative in healthcare settings can significantly reduce anxiety levels and improve the mental health of isolated healthcare workers. These findings highlight the need for regular mental health assessments and interventions as part of healthcare worker wellness programs.

### **Recommendations**

As the data shows benefit of the intervention, the researcher feels the need to promote mental health programs in healthcare settings. The researcher recommends exploring more and recommend on the following:

1. To integrate Watson's CARE Program at the PHC, on existing policies such as the "NO COMPANION, NO VISITOR" policy in postoperative units is designed to minimize infection risks but may inadvertently contribute to feelings of isolation among patients.
2. Integrating the principles of Watson's Theory into PHC's practices could involve implementing structured support programs like the CARE Program, which focuses on fostering authentic, trusting relationships, and creating a caring-healing environment. This approach can mitigate the psychological impact of isolation policies, promoting mental well-being among patients.
3. Furthermore, PHC's commitment to nursing education, as evidenced by its various training programs, provides an opportunity to incorporate Watson's

caring principles into curricula. By educating nurses on these concepts, PHC can cultivate a workforce adept at providing compassionate, holistic care, thereby enhancing patient outcomes and staff satisfaction.

4. Health care institutions to implement structured programs like Watson's COVID-19 awareness initiative in their healthcare settings that can significantly reduce anxiety levels and improve the mental health of isolated healthcare workers. These findings highlight the need for regular mental health assessments and interventions as part of healthcare worker wellness programs.
5. Counseling and aide for those with noted high or significant level of anxiety. Since anxiety is noted as a silent cry, health care workers may not manifest any symptomology yet deep inside, they may be battling their fears and anxiety.
6. Similar interventions can be tailored for different healthcare roles, cultural contexts, and stressors beyond isolation to address the broader mental health needs of healthcare workers.
7. For future researcher to explore further the effects of such programs in terms of anxiety and technological exploration. Incorporating technology, such as virtual delivery of these programs, could enhance accessibility and scalability, particularly during pandemics. Future research should evaluate the long-term effects of Watson's program on anxiety levels to determine its sustainability and continued benefits.

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## Appendices

## Appendix A

### Summary of Clinical Caritas Processes

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
	Formation of humanistic-altruistic system of values	Practice of loving-kindness and equanimity within context of caring consciousness	<p>“My respect for this patient allowed me to be available to him / her.”</p> <p>“I paused to listen.”</p> <p>Mutuality</p> <p>Congruence</p> <p>Feeling valued</p> <p>Honored to be allowed into other’s space.</p> <p>Connectedness</p> <p>Validation</p>	<p>Altruistic loving-kindness. Nurse-related growth might be reflected in whole narrative.</p> <p>Humanism</p> <p>Considers patient as complete individuals, nurse shows that he or she is interested in more than a health problem.</p>

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
			<p>Welcome to work.</p> <p>Make space for others.</p> <p>Make self-available to others.</p> <p>Vulnerability-ask for what you need.</p> <p>Model self-care and caring for others.</p> <p>Acknowledge acts of kindness.</p>	<p>See things from the patient's point of view.</p> <p>Accepts patient as he or she is without prejudice,</p> <p>Shows patients respect - as well as those closest to them.</p> <p>Is humane, warm with patients and those closest to them</p>
	Instillation of faith-hope	Being authentically present, and enabling and sustaining the deep	Honor the beliefs and values of patients, families by being present to their needs.	Hope as a product Unique understanding of the person

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
		belief system and subjective life world of self and one-being-cared-for	<p>“By listening, I was able to honor this patient’s belief system and enable him / her to feel his own sense of faith / hope.</p> <p>Self-care -self awareness</p> <p>Intentional acts of self-care</p> <p>Accurate identification of person by preferred name</p> <p>Eye contact as appropriate</p> <p>Acknowledging</p> <p>Respect</p> <p>Celebrating</p> <p>Value</p>	<p>Shows patients that he or she will be there for them if they need something.</p> <p>Encourage patients to have confidence in themselves.</p> <p>Draws patients’ attention to positive aspects concerning them and their state of health.</p> <p>Helps them find motivation to improve their state of health.</p> <p>Emphasizes patients efforts.</p>

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
			<p>Honoring unique gifts and talents to others</p> <p>Create opportunities for silence / reflection / pause.</p> <p>Ability to be in silence.</p> <p>Release control</p>	<p>Encourages them to be hopeful when it is appropriate.</p> <p>Takes into account what they know about their health situation.</p>
	Cultivation of sensitivity to oneself and to others	Cultivation of one's own spiritual practices and transpersonal self, going beyond ego self	<p>Nurture and cultivate individual spiritual practices and beliefs.</p> <p>"By being more responsive to the patient's needs and feelings, I was able to create a more trusting relationship."</p> <p>Forgiveness</p> <p>Blessing</p>	<p>Sensitivity</p> <p>Going beyond self</p> <p>Watson "pause"</p> <p>Best interest of patient beyond own thoughts</p> <p>Patient is an example.</p>

<p>Clinical Caritas Processes #</p>	<p>Original Ten Carative Factors</p>	<p>Caritas Processes (Watson, n.d.)</p>	<p>Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)</p>	<p>Clinical Narrative related to Carative Factors (Norman et al., 2008)</p>
			<p>Meaningful rituals for practicing gratitude and forgiveness</p> <p>Transform tasks into caring healing activities.</p> <p>Journaling-self exploring</p>	<p>Asks patients how they would like things done.</p> <p>Shows awareness of their feelings and of those closest to them</p> <p>Knows how to choose the right moment to discuss patient's condition and the steps to come.</p> <p>Makes patients aware of the way those closest to them are experiencing.</p>

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
				Keeps those closest to patients up to date about patient's state of health (with patient agreement)
	Development of a helping-trusting, human caring relationship	Developing and sustaining a helping-trusting, authentic caring relationship	Developing helping-trusting caring relationships with patients, families, and members of the healthcare team Accurate detect other's feelings. Hear other's story. Cultivate self-awareness. Listening Hold other with unconditional love and regard.	Trust as a product Accepting the person Awareness of own feelings (nurse) Listens to patients attentively when they speak, as well as those closest to them. Introduces self by stating name and function.

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
			<p>Non-judgmental attitude</p> <p>Allow inner spirit to shine.</p> <p>Respond to other's feelings with congruence – hold other's feelings / affective congruence</p>	<p>Answers as soon as it is convenient when patient calls.</p> <p>Does what he or she said they would do (follows through)</p> <p>Does not seem busy or otherwise occupied when taking care of patient.</p> <p>Does not cut patient off when he speaks.</p> <p>Does not confront too harshly patient ideas and behaviors</p>

<p>Clinical Caritas Processes #</p>	<p>Original Ten Carative Factors</p>	<p>Caritas Processes (Watson, n.d.)</p>	<p>Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)</p>	<p>Clinical Narrative related to Carative Factors (Norman et al., 2008)</p>
	<p>Promotion and acceptance of the expression of positive and negative feelings</p>	<p>Being present to, and supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for</p>	<p>Promote and support the expression of both positive and negative feelings a way to understand other's perceptions and experiences.  The caring relationship in a caring environment promoted spiritual growth.  Tell own story and hear other's story.  Allow story to emerge.  Acknowledge healing as an inner journey.  Hold safe space.  Allow for the unknown and uncertainty.  Reflection of feelings</p>	<p>Acceptance of person <i>no matter what</i> positive / negative feelings are coming out.  Allowing intuition  Going beyond  Knowing when art goes beyond science of nursing.  Expression of emotions  Encourages patients to speak their thoughts and feelings freely.  Keeps calm when a patient or family member is angry.</p>

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
			Praying with families as appropriate Offer blessings	Does not "reduce" his or her presence when a patient has a difficult moment. Helps patients channel difficult emotions. Let patients express their pain, sadness, fears
	Systematic use of a creative problem-solving caring process	Creative use of self and ways of knowing as part of the caring process; to engage in	Cocreate creative-aesthetic caring healing practices with patient / family and health care team to address needs of patients and families. Exercise patient-centered problem solving.	Art / artistry creative - not the norm Problem solving Helps patient set realistic objectives that take health condition into account.

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
		artistry of caring-healing practices	<ul style="list-style-type: none"> <li>Self as environment</li> <li>Blessings</li> <li>Touch</li> <li>Voice</li> <li>Play</li> <li>Movement</li> <li>Music</li> </ul>	<p>Helps patients cope with the stress of their condition or general situation.</p> <p>Helps patient recognize the means to efficiently resolve problems.</p> <p>Tries to identify with patient the consequences of behavior.</p> <p>Informs patients and those closest to them about resources adapted to their needs</p>

<p>Clinical Caritas Processes #</p>	<p>Original Ten Carative Factors</p>	<p>Caritas Processes (Watson, n.d.)</p>	<p>Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)</p>	<p>Clinical Narrative related to Carative Factors (Norman et al., 2008)</p>
	<p>Promotion of transpersonal teaching-learning</p>	<p>Engaging in genuine teaching-learning experience that attends to unity of being and meaning attempting to stay within other's frame of reference</p>	<p>Engage in teaching-learning experiences that address the individual/family needs and learning style.  Promotes knowledge, growth, empowerment and healing processes and possibilities for the patient and nurse.  Collaborative participation  Coaching  Engagement from family/patient perception  Learn first from family, then share / coach / provide information / tools / options.  Honesty</p>	<p>Developmentally and culturally appropriate  Helps the patient identify, formulate, and ask questions about an illness and its treatment.  Gives the patient necessary information or makes it available so the patient can make informed decision.  Explains to the patient the care of treatment beforehand.</p>

<p>Clinical Caritas Processes #</p>	<p>Original Ten Caritasive Factors</p>	<p>Caritas Processes (Watson, n.d.)</p>	<p>Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)</p>	<p>Clinical Narrative related to Caritasive Factors (Norman et al., 2008)</p>
			<p>Accuracy</p> <p>Preparation measures – breathing, relaxation, what will see feel, hear, taste.</p> <p>Caring practices</p>	<p>Does not use terms or language that the patient or family / significant other cannot understand.</p> <p>Uses a respectful pace when giving information of answering questions.</p> <p>Teaches the patient how to schedule and prepare medications.</p> <p>Gives the patient indications and means to treat or prevent side effects of medications or treatments</p>

<p>Clinical Caritas Processes #</p>	<p>Original Ten Carative Factors</p>	<p>Caritas Processes (Watson, n.d.)</p>	<p>Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)</p>	<p>Clinical Narrative related to Carative Factors (Norman et al., 2008)</p>
	<p>Provision for a supportive, protective, an / or corrective mental, physical, societal, and spiritual environment</p>	<p>Creating healing environment at all levels (physical, as well as non-physical, subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are</p>	<p>Provision for a supportive, protective, and / or corrective mental, physical, societal, and spiritual environment          Create caring-healing environments for physical, emotional, mental and spiritual self.          “By promoting the caring relationship, I created space for this patient to generate his own wholeness and healing.”          Nurse as environment          Patient as person</p>	<p>Holistic, protective – at all levels          Understands when patients need to be alone.          Helps the patient be comfortable (e.g., offers back rubs, helps position changes, adjusts lighting, suggests special equipment)          Puts room back in order after having taken care of the patient.          Reassesses the patient for symptoms following an intervention.          Respect the patient privacy.</p>

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
		potentiated	<p>Create familiar environment (e.g., items from home, loved ones, wear own clothes, maintain own schedule)</p> <p>Hand washing</p> <p>Privacy</p> <p>Comfort</p> <p>Eye to eye communication and contact</p> <p>Bring in aesthetic-art, nature.</p> <p>Music</p> <p>Quiet time</p>	<p>Before leaving the patient room, ask to see if the patient has everything needed.</p> <p>Help the patient clarify which things that significant persons should bring</p>

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
			<p>Nightingale's theory of modifying the environment to promote health (e.g., providing clean air, water, light sound)</p> <p>Patient body as healing environment – clean hair / body / bowel</p> <p>Dignity of body</p> <p>Safety</p> <p>Cleanliness</p> <p>Family-patient time frames</p> <p>Environmental rituals</p> <p>Permission to enter</p>	

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
	Assistance with gratification of human needs	Assisting with basic needs with an intentional caring consciousness, administering "human care essentials," which potentiate alignment of mind, body, spirit, wholeness, and unity of being in all	Support other's unity and wholeness by assisting with basic physical, emotional, mental, and spiritual needs. "I was able to help meet the needs this patient identified for him/herself." Art Touching Singing Play as work of children. Quiet time Doing for other as they would do for themselves if able.	Nursing tasks with a holistic approach Helps the patient with care they cannot give themselves. Know how to give treatments. Know how to operate special equipment. Do treatments or give medications on time. Encourage those closest to patient to support them. Closely monitor health condition

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
		aspects of care; tending to both embodied spirit and evolving spiritual emergence	Actions emerge from caring intention	<p>Help patients feel that they have control over the situation.</p> <p>Know what to do in situations where one must act quickly.</p> <p>Show ability and skill in how interventions are delivered.</p> <p>Take basic needs into account (e.g., sleep, hygiene)</p>
	Allowance for existential-phenomenological-spiritual	Opening and attending to spiritual-mysterious and	<p>Allow miracles to take in place.</p> <p>Caring calls for advanced competency and skill in authentically engaging in caring for the patients.</p>	<p>Spiritual level</p> <p>Loss, crisis</p> <p>Help patients feel well in their condition.</p>

Clinical Caritas Processes #	Original Ten Carative Factors	Caritas Processes (Watson, n.d.)	Actions and Behaviors for Caring Factors (D' Alfonso et al., 2007)	Clinical Narrative related to Carative Factors (Norman et al., 2008)
	forces	existential dimensions of one's own life-death; soul care for self and the one-being-cared-for	Nurture / support hope Allow for the unknown Acknowledge what we don't know. Allow for paradox. Sharing Participation	Recognize that prayer, meditation, and other means can help appease them and give them hope. Help patients explore what is important. Help patients explore the meaning that they give to their health condition. Help patients look for a certain equilibrium / balance in their lives. Take into consideration the spiritual needs of patients

#	CARING CONSTRUCT	Clinical Caritas Processes
1	<p><b>Respectful: courteous regard for the other</b>  <b>(Comforts; establishes and maintains a helping / trusting relationship; respects individuality)</b></p>	1, 3, 4
2	<p><b>Knowledge and Skill: nurse caring as proficient, informed, and skillful (explains and facilitates; monitors and follows through; teaches and evaluates learning; assists with human needs; is competent practitioner; coordinates care; provides emotional support; provides physical comfort; involves patient / family; creates healing environment for physical and spiritual self; assists with physical, emotional, and spiritual human needs)</b></p>	4, 8, 9

3	<p><b>Connectedness: optimistic and constant readiness on part of nurse to help the other (operates from perspectives of humanism/faith-hope-sensitivity; instills faith and hope; accepts positive/negative expressions; provides emotional support; is open to extraordinary events)</b></p>	2, 5
4	<p><b>Assurance: investment in other's needs and security (Is supportive/protective/corrective; maintains safe physical environment)</b></p>	8
5	<p><b>Attentiveness: appreciation of and engrossment in the other's perspective and experience (is accessible, anticipates patient's, family's caregiver's needs; considers existential/ phenomenological dimensions; respects cultural and spiritual practices, beliefs, and needs)</b></p>	2, 10
6	<p><b>Collaboration: engagement in collegial, interdependent partnership (Cooperative; interdisciplinary shared planning; open coordination and communication; shares decision making, problem solving, responsibility, and goal setting)</b></p>	6, 7

## APPENDIX B

### The Caring Protocol

<p><b>The Caring Protocol: Standard of Practice focuses on the nurse and patient, family, and caregiver. Nurses are intentional as they:</b></p> <ul style="list-style-type: none"><li><b>Reflect and center on the care to be provided to the patient.</b></li><li><b>Are intentional and mindful or conscious about being caring and present.</b></li><li><b>Are aware that the nurse-patient relationship takes place in a zone of intimate or personal space.</b></li><li><b>Are authentically present and engaged in patient's situation.</b></li><li><b>Live in the moment, occasion, or situation of the patient no matter how short</b></li><li><b>Realize that they have the capacity to be the healing environment for the patient.</b></li><li><b>Are aware that caring activities (actions and behaviors) occur simultaneously with other activities.</b></li><li><b>Take care of self, other nurses, other members of the team, family, and other caregivers</b></li></ul>	
<p><b><i>Caring</i></b> <b><i>Construct 1</i></b> <b><i>CF 4</i></b></p>	<p><b>Respectful: courteous regard for the other</b>  (Comforts; establishes and maintains a helping / trusting relationship; respects individuality)</p>
	<p>Intends to enhance patient's welfare/situation by caring about, for, and with him/her</p>

	Acts courteously and deferentially
	Introduces self and identifies title
	Maintains professional boundaries with patient and family
	Calls patient by his/her preferred name
	Acts in genuine manner to create a therapeutic relationship with patient
	Positions body and uses nonverbal indicators of connection to demonstrate a focus on patient and family
	Explains specific roles of members of the healthcare team
	Reviews visitation policy with patient and family
	Explains physical space of unit to patient and family, including location of bathroom
	Respects patient's dignity
	Keeps patient information confidential
	Provides privacy for patient and family wherever care is provided
	Protects patient's rights
	Establishes trusting relationship with patient and family
	Shows concern for patient and about patient's situation
	Expresses concern regarding patient's injury, illness, or situation

	Explains nurse's role in his/her care that day to patient
	Involves patient and family in care
	Supports patient's independent decisions
	Sustains eye contact during interaction with patient and family consistent with cultural practices
	Listens patiently to patient and family
	Is empathetic with patient and family
	Is gentle
	Accepts patient's silence
	Demonstrates no biases
	Is honest with patient and family and provides honest answers
	Gives feedback to patient and family
	Follows up and follows through with patient and family as promised
	Keeps relatives informed about a patient consistent with patient's wishes
	Respects patients expressed wishes regarding end-of-life care
<b><i>Caring</i></b> <b><i>Construct 2</i></b>	<b>Knowledge and Skill: nurse caring as proficient, informed, and skillful</b> (explains and facilitates; monitors and follows through; teaches and evaluates learning; assists with human needs; is competent practitioner;

	coordinates care; provides emotional support; provides physical comfort; involves patient / family; creates healing environment for physical and spiritual self; assists with physical, emotional, and spiritual human needs)
	Creates a healing physical environment for patient and family, including noise control, sufficient light and warmth, odor control, art, and <b>comfort</b>
	Meets patient's physical needs
	Measures patient's vital signs
	<b>Monitors patient's status</b>
	Assists patient and family with ADLs (bathing, toileting, dressing, transferring, walking)
	Acts promptly to decrease patient's discomfort, distressing symptoms, and suffering
	<b>Checks on and documents patient's pain, fatigue, distress, and anxiety</b>
	<b>Evaluates patient's sleep patterns</b>
	Responds in timely manner to indicators of patient deterioration
	Performs comprehensive assessment of needs and concerns from patient's frame of reference
	Provides food and beverages as needed and allowed
	Demonstrates professional competence with clinical procedures
	Give patient treatments and medications on time

	Observes and evaluates effects of medication on patient within 30 to 60 minutes of medication administration
	<b>Demonstrates proficiency with interpersonal skills</b>
	Provides emotional support for patient and family
	Responds to, reassures, empathizes with, and consoles patient and family
	Supports patient and family through dying and grieving processes
	<b>Communicates realistic and liberal time expectations for various stages in process of care</b>
	Teaches patient and family by explaining procedures, treatments, treatment alternatives, medications, and rationales for interventions
	Reviews medication side effects
	Explains details of every intervention and procedure to patient and family before procedure begins
	<b>Encourages patient to perform self-care</b>
	Instructs patient and family about aspects of self-care
	Helps patient to mobilize necessary resources
<b><i>Caring Construct 3</i></b> <b><i>CF 2, 5</i></b>	<b>Connectedness: optimistic and constant readiness on part of nurse to help the other</b> (operates from perspectives of humanism/faith-hope-sensitivity; instills faith and hope; accepts positive/negative expressions; provides emotional support; is open to extraordinary events)

	Uses handshake or touch on arm if acceptable to patient
	Is available/accessible to patient and family
	Engages in patient's and family's situation
	Promotes patient's self-esteem
	Is hopeful and cheerful with patient
	Is truthful and realistic about patient's situation
	Reassures patient and family about clinical procedure
	Asks patient if he/she has any needs
	Encourages patient and family to ask questions
	Asks patient and family if questions were answered clearly and needs were met
	Encourages patient to express feelings about his/her disease and treatment
	Encourages patient to express his/her feelings, beliefs, concerns, and positive and negative feelings
<b>Caring</b> <b>Construct 4</b>	<b>Assurance: investment in other's needs and security</b> (is supportive/protective/corrective; maintains safe physical environment)
	Watches over patient with vigilance
	Conducts proactive, hourly rounds on patient

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

<b>Construct 5</b>	accessible, anticipates patient's, family's caregiver's needs; considers existential/ phenomenological dimensions; respects cultural and spiritual practices, beliefs, and needs)
	Gets to know patient as a person
	Learns patient's story, situation, and context
	Seeks to discover client's values, beliefs, and desires
	Supports patient's beliefs and values
	Supports patient's spiritual, emotional, mental, physical, cultural, and social needs
	Acts sensitively with patient and family
	Engages in patient's and family's experience
	Pays attention to patient's healing
	Anticipates patient's needs and concerns
	Verifies patient's and family's understanding
	Evaluates meaning of subjective and objective patient concerns
	Acknowledges and responds to patient's description of priority needs and concerns
	Explains that patient's condition may alter which priority needs and goals are met first
	Advocates for patient in culturally sensitive manner

	Supports patient's culturally based practices
	Pays attention to gender issues and sexual concerns
	Sustains continuing caring relationship with patient and family
<b>Caring Construct 6 CF 6</b>	<b>Collaboration: engagement in collegial, interdependent partnership</b> (Cooperative; interdisciplinary shared planning; open coordination and communication; shares decision making, problem solving, responsibility, and goal setting)
	Sustains continuing caring relationship with patient and family
	Extends community of caring to fellow nurses, patient, family, and other departments/services
	Discusses with patient and family the contributions of different members of the healthcare team to patient's plan of care and implementation of care
	Contributes to the community of caring among all healthcare providers so that the needs of patients and family dominate
	Communicates with patient and family using strategies that match where he/she and they are
	Fosters collaboration among caregivers by communicating and planning with caregivers, patient, and family
	Conducts routine, interdisciplinary rounds with members of healthcare team, patient, and family to foster ongoing communication
	Implements plans for direct communication with patient, family, other nurses, physicians, and healthcare team member to

	assure continuity of care
	Communicates effectively with patient, family, physicians, other nurses, and all services/department in organization concerning patient and family
	Communicates process of care and expected treatment to team so patient, family, nurses, physicians, and other care providers know about tests, procedures, test results, etc., and changes in plan of care
	Communicates plan of care in writing and verbally to members of the interdisciplinary healthcare team
	Documents patient information in patient record
	Sits with patient for at least 5 minutes per shift to plan and review patient's plan of care
	Assists patient in decision-making and planning
	Alerts members of healthcare team to the need of nursing staff to know and be a part of details of end-of-life communications
	Supports decisions regarding patient's immediate and long-term future
	Cocreates a plan for comprehensive caring and healing that is coordinated with medical plan of care for patient and family
	Refers patient and family concerns and problems to members of the interdisciplinary healthcare team consistent with their expertise
	Explains rationale for referring patient's and family's concerns and problems to other members of the healthcare team
	Oversees comprehensive care planning

	Assures performance of comprehensive care planning
	Facilitates seamless care
	Follows through with prioritized plan of care

## APPENDIX C

### Permission from the Author of Caring Protocol and STAI - Stait Trait Anxiety Inventory



Effect

health Care Workers103  
Illippine Heart Center



**Zane Wolf**

Sun, Dec 12, 2021, 10:05 AM

Dear Ms. Ongpauco: Three of us ( P. Keeley, L. Regul, and I) give you permission to use the caring protocol. We wish you the best success. I will send a note to



**Jane Ivah Ongpauco**

Mon, Dec 13, 2021, 4:23 PM

Thank you so much for granting me your permission. Regards to you all and stay safe 🙏😊 Sent from my iPhone On Dec 12, 2021, at 10:05, Zane Wolf <wolf@i



**Pat Keeley**

Fri, Jan 14, 9:06 PM (9 days ago)

Hello Anne, It was good to hear from you. Here is the email response sent by Zane regarding use of the Caring Protocol at Philippine Heart Hospital in Manila. A



**Anne Jadwin** <aejadwin@gmail.com>

Fri, Jan 14, 9:41 PM (9 days ago)



to Pat, Faithmy0811, Zane, me ▾

Happy to approve as well, best of luck moving forward with the implementation. Anne Jadwin



**Jane Ivah Ongpauco** <janeivahperez@gmail.com>

Sat, Jan 15, 9:45 PM (8 days ago)



to Anne ▾

Thank you so much everyone.

Stay safe and healthy.



## Your message to Mind Garden Customer Service

Your message has been sent successfully.

**Message:** Good day,

I am Jane Ivah P. Ongpaucio, unit manager from Philippine Heart Center, Manila Philippines. I am currently working on my Thesis paper and asking for your permission for me to use Dr. Spielberger's State-Trait Anxiety Inventory (STAI). I am planning to implement it in our COVID19 wards to evaluate how it affects patients anxiety level on care.

Thank you. Looking forward for your response.

**Company:** Philippine Heart Center

**Country:** Philippines

## Your message to Mind Garden Customer Service

Your message has been sent successfully.

**Message:** Good day,

I am Jane Ivah P. Ongpaucio, unit manager from Philippine Heart Center, Manila Philippines. I am currently working on my Thesis paper and asking for your permission for me to use Dr. Spielberger's State-Trait Anxiety Inventory (STAI). I am planning to implement it in our COVID19 wards to evaluate how it affects patients anxiety level on care.

Thank you. Looking forward for your response.

**Company:** Philippine Heart Center

**Country:** Philippines

Re: [Mind Garden] Message from contact form - Order Questions Inbox x



**Mind Garden Inc** <info@mindgarden.com>

to me ▾

Mon, Jan 24, 11:45 AM (4 days ago)



Hello Jane,

Thank you for your message.

As you may know, the STAI is a copyrighted instrument and each use/administration of the STAI requires license purchase, e.g. to survey 100 people each twice with the STAI to assess results pre/post meditation exercises and at five time points, you would buy a license for 1,000 administrations. Type in your quantity needed on the applicable product page below. Press your Tab key, and all available volume discounts will be applied. Minimum quantity is priced at \$2.50 each. For quantity 100+ on a single invoice, unit price drops to \$1.75. Additional unit price breaks are available at quantity 500+ and 1,000+ on a single invoice.

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You may also be interested in the [STAI Manual](#) (\$50) which includes info on STAI reliability, validity, normative data, etc.

Best,

Katherine  
Mind Garden, Inc.

On Sat, Jan 22, 2022 at 10:08 PM <info@mindgarden.com> wrote:

# **Self-Evaluation Questionnaire**

## **STAI Form Y-1 and Form Y-2**

**Developed by Charles D. Spielberger**

in collaboration with R.L. Gorsuch, R. Lushene, P.R. Vagg, and G.A. Jacobs

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## Appendix D

### Watson's CARE (COVID 19 Awareness & Related Experience) Program

- This refers to the admission of care to patients in COVID 19 wards. This utilizes Watson's Theory of Care. This program is derived from the Caring Protocol developed by

Wolf, Bailey, & Keeley (2014). It comprised of six (6) Caring Constructs which operates from the ten (10) Clinical Caritas Processes based on Jean Watson's Theory.

No.	Caring Interventions										
<p><b>Orientation Phase</b> – refers to the first 10 (ten) minutes of registration and orientation to patient thru phone call. This phase is directed in establishing a caring environment while identifying nursing problems.</p>											
	Caring Interventions	Clinical Caritas Processes									
		1	2	3	4	5	6	7	8	9	10
	<p>Call the patient thru phone. Greet the patient.</p> <p>Introduce yourself to the patient by stating your name and explain nurse's roles in his/her care.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



<p><i>gandang araw po. Ako po si _____. Ako po ay ang CARE nurse niyo dito sa Philippine Heart Center.”</i></p>											
<p>Refer to the patient by his / her name.</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<p>Provide privacy for the patient.</p>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<p>Ensure patient’s comfort.</p>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<p>Explains CARE nurse’s role in his/her care that day to patient</p>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<p>Monitors patient’s status</p>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<p>Ask the patient how he / she feels. Inquire about his / her concerns and attentively listen to what he / she says.</p>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<p>Acknowledges and helps patients express their pain, sadness, and fears. <i>“Naiintinidihan ko po na kinababahala nyo po kung ano po ang lagay niyo”</i></p>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

	Is available / accessible to patient.  <i>“Kung may kailangan po kayo, tawagan niyo lang po ako sa ganitong number _____. Babalik-balikan ko po kayo.”</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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No.	Caring Interventions											
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**Working Phase** – refers to the time from the start and ends after treatment has been given. The goal is to maintain the caring environment while treatment is being given.

	<b>Caring Interventions</b>	<b>Clinical Caritas Processes</b>									
--	-----------------------------	-----------------------------------	--	--	--	--	--	--	--	--	--

		1	2	3	4	5	6	7	8	9	10
--	--	---	---	---	---	---	---	---	---	---	----

	.Checks on and documents patient’s anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	.Evaluates patient’s sleep patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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	.Encourages patients to perform self-care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	. Teaches patient and family by explaining procedures, treatments, treatment alternatives, medications, and rationales for intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	. Perform call rounds. <i>"Kumusta na po ang pakiramdam nyo?"</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	. Continuously communicate the process of care and the expected treatment to the patient. Make sure that the patient knows what to expect next, communicate realistic and liberal time expectations for the various stages in the process.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	. Ask the patient, "do you have any questions or needs?" every time you interact with the patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	. Consider the spiritual needs of the patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

	.When questions are asked about delays or treatment, advise the patient that you will have to check on the request.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No.	Caring Interventions	rationale									
<b>Termination Phase</b> – starts when there is a definite plan for patient for clearance. This phase creates a caring experience while the patient is being prepared to go back to work.											
		<b>Clinical Caritas Processes</b>									
		1	2	3	4	5	6	7	8	9	10
	. Inform the patient of the progress of his / her care; what he / she expects; provide health teachings as necessary.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	. Impart words of hope as the patient is cleared for work	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## APPENDIX E

### Instructional Design

Date / Time	
Behavioral Objective	<p>Discuss the impact of the philosophy and vision of the Nursing Department on caring activities in the organization.</p> <p>Examine the association among self-developed competencies, family systems, nursing education programs, and workplace culture on caring activities.</p>
Content	<p>Philosophy and Vision of Nursing Department</p> <p>Relationship of caring competencies to self-care, family systems, nurse education programs, and workplace culture</p> <p>Caring for self, colleagues, and patients</p> <p>Caring competencies: implicit and explicit manifestations</p> <p>Workplace culture in support of compassion, caring, collaboration, evidence-based practice, patient safety</p>
Teaching Method	<p>Discussion</p>

Time	7 minutes
Resources	PowerPoint Presentation
Evaluation Method	Reflections / Oral feedback

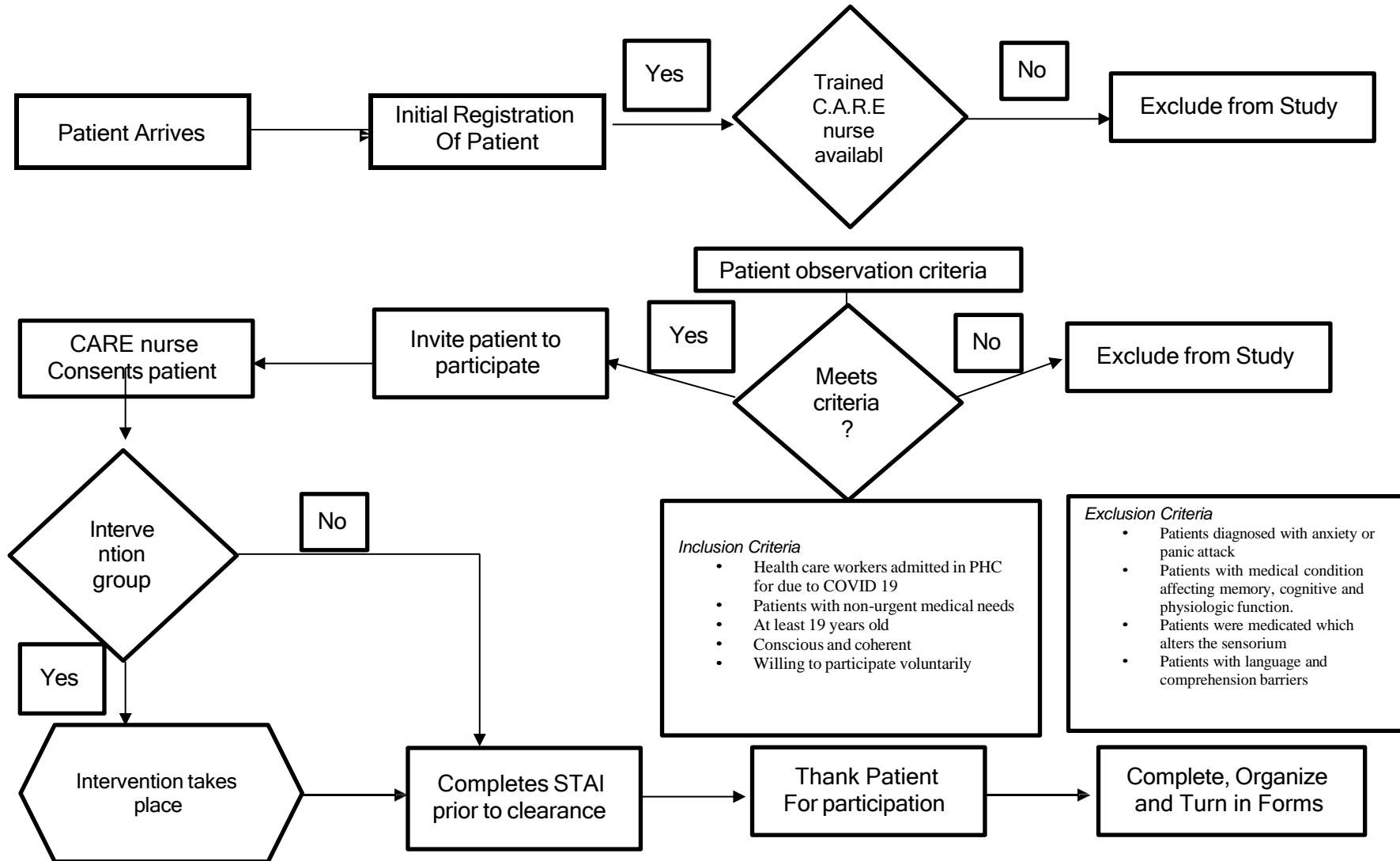
Date / Time	
Behavioral Objective	Identify nursing theory's formulations and its influence on clinical practice
Content	Jean Watson's Caring Theory Caritas processes
Teaching Method	Discussion
Time	5 minutes
Resources	PowerPoint Presentation
Evaluation Method	Reflections / Oral feedback

Behavioral Objective	<p>Relate reasons for becoming a nurse.</p> <p>Describe caring perceptions, caring constructs, and caring activities.</p> <p>Link reporting near misses in support of patient safety</p> <p>Discuss patterns in caring scholarly literature.</p> <p>Describe caring moments and caring activities that stand out in professional practice.</p> <p>Explain caring protocol</p>
Content	<p>Reasons for entering the nursing profession.</p> <p>Caring moments and caring activities</p> <p>Constructs: Respectful; Connectedness; Assurance; Knowledge and skill; Attentiveness; Collaboration</p> <p>Anxiety Tool - STAI Y1</p>
Teaching Method	Discussion
Time	15 minutes

Resources	Powerpoint Presentation
Evaluation	Reflections / Oral feedback
Method	Handout: Caring Protocol

## APPENDIX F

### Watson's CARE Study Protocol



## APPENDIX G

### Interview Questionnaire

Patient Study #	Date:	Interviewer:
-----------------	-------	--------------

#### Socio-demographic Profile

Age: <i>Edad:</i>	
Sex: <i>Kasarian:</i>	<input type="checkbox"/> Male ( <i>Lalake</i> )  <input type="checkbox"/> Female ( <i>Babae</i> )
Educational Attainment:  <i>Antas ng Edukasyon:</i>	<input type="checkbox"/> Elementary Level/Graduate  <input type="checkbox"/> Highschool Level/Graduate  <input type="checkbox"/> Vocational Course  <input type="checkbox"/> College level  <input type="checkbox"/> College Graduate  <input type="checkbox"/> Masters/Doctorate
Employment Status:  <i>Katayuan ng trabaho:</i>	<input type="checkbox"/> Employed Occupation: _____ ( <input type="checkbox"/> full time, <input type="checkbox"/> part time  <input type="checkbox"/> retired: Previous Work: _____  <input type="checkbox"/>  Others: _____
Family Structure:	<input type="checkbox"/> lives alone: _____  <input type="checkbox"/> Parents and Children  <input type="checkbox"/> parents, Children, grand-children and  others: _____

<i>(Istraktura ng Pamliya)</i>	( ) others: _____
--------------------------------	-------------------

## Appendix H

### STAI Y1 Questionnaire

Patient Study #	Date:	Validated by:
-----------------	-------	---------------

Please put an X in the box that best describes your feelings.


*(Lagyan ng X ang kahon na pinaka naglalarawan sa iyong saloobin)*

<u>Self - evaluation questionnaire</u>  <i>(Talatanungan sa pagsusuri sa sarili)</i>	STAI Form Y-1			
	1	2	3	4
	Not at all <i>(Hindi talaga)</i>	Somewh at <i>(Medyo)</i>	Moderately <i>(Katamtaman )</i>	Very Much so <i>(Sobra)</i>
1. I feel calm <i>(Ako ay kalmado)</i>				
2. I feel secure <i>(Matiwasay ang pakiramdam ko)</i>				
3. I am tense <i>(Ako ay tensyonado)</i>				
4. I feel stained <i>(Pakiramdam ko na ang pagkatao ko ay nadungisan)</i>				
5. I feel at ease <i>(Maginhawa ang pakiramdam ko)</i>				
6. I feel upset <i>(Ako ay malungkot)</i>				
7. I am presently worrying over possible misfortunes <i>(Ako ay</i>				

<i>kinakabahan sa mga posibleng kasawian)</i>				
8. I feel satisfied ( <i>Ako ay kuntento</i> )				
9. I feel frightened ( <i>Ako ay natatakot</i> )				
10. I feel comfortable ( <i>Ako ay komportable</i> )				
11. I feel self-confident ( <i>Ako ay may kumpyansa sa sarili</i> )				
12. I feel nervous ( <i>Ako ay kinakabahan</i> )				
13. I am jittery ( <i>Ako ay kinikilabutan</i> )				
14. I feel indecisive ( <i>Ako ay may agam-agam</i> )				
15. I am relaxed ( <i>Ako ay relaks</i> )				
16. I feel confident ( <i>Ako may tiwala sa sarili</i> )				
17. I am worried ( <i>Ako ay nag-aalala</i> )				
18. I feel confused ( <i>Ako ay nalilito</i> )				
19. I feel steady ( <i>Matibay ang loob ko</i> )				
20. I feel pleasant ( <i>Kaaya-aya ang pakiramdam ko</i> )				

# APPENDIX I

## Letter to the Research and Ethics Committee

 **PHILIPPINE HEART CENTER**  
Education, Training and Research Services  
Clinical Research Department  
**CLINICAL TRIAL AND RESEARCH DIVISION**  
9<sup>th</sup> Floor Medical Arts Building, East Avenue, Quezon City 1100, Philippines  
☎ 8252471-50 local 3800 Email address: phcresearch@phc.com

May 18, 2023

*APR 14 2023*

**JOEL M. ABANILLA, M.D.**  
Executive Director  
Philippine Heart Center

Thru : **GILBERT C. VILELA, M.D.**  
Executive Director  
Education, Training and Research Services

**MARIA TERESA B. ABOLA, M.D.**  
Department Manager III  
Clinical Research Department  
Philippine Heart Center

**ALEXANDER A. TUAZON, M.D.**  
Division Chief  
Clinical Trial and Research Division

**RAFAEL R. TENORIO, M.D.**  
Chairman  
Institutional Ethics Review Board  
Philippine Heart Center

*6/14/23*  
*6/8/2023*  
*5/31/23*  
*since PHC research policy requirements are confidential with*  
*Signature of J. Vilela*  
*Review policy*  
*Review for approval*

Dear Doctor:

Greetings of Peace!

I am currently pursuing my thesis in Master of Arts in Nursing at University of the Philippines Open University. In this regard, I would like to request your kind permission for me to conduct my study in our Institution. My study is about the Effect of the Watson's Covid 19 Awareness and Related Experience (C.A.R.E.) Program in reducing the anxiety level of Isolated Health Care Workers with COVID19 at Philippine Heart Center which will involve health care workers who are currently employed. I will be conducting my survey via digital platform. Accomplishment of survey will take approximately 15 minutes.

Should you have any query, I may be contacted through my mobile number : 097-847-7818. I truly appreciate your support on this endeavor.


Sincerely,

*Jane P. Ongpasuco*  
Jane P. Ongpasuco, RN  
Head Nurse, Petal 5AB/Presidential Suite

Noted by:  
*Rita C. Ramos*  
Rita C. Ramos, RN, MAN  
Research Adviser  
Assistant Professor and Secretary to the Faculty of Education  
University of the Philippines, Open University

**APPENDIX J**

**Routing Slip**

 **PHILIPPINE HEART CENTER**  
East Avenue, Quezon City

**ROUTING SLIP**

RS-N-GND-MS2-W5B-2024-027

**FOR** : CRISELLE M. GALANG, RN, DPM  
Deputy Executive Director, Nursing Services

**FROM** : HEAD NURSE, PETAL 5B


**RE** : POST GRADUATE THESIS


**DATE** : May 29, 2024


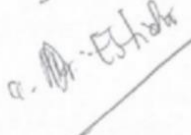

Submitting herewith my request letter to conduct data gathering here at Philippine Heart Center, for my post graduate thesis. Attached are the study protocol and process flow.

For your approval,

Sincerely,

  
Jane Ivalde P. Ongpauco, RN  
Head Nurse, Petal 5B, Nurse V

  
JUN 03 2024

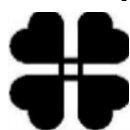
ion, as part of a Masteral  
y. I would be grateful for  
d hopefully improve our  
the use evidence-based  
of Health Care workers  
that I carried out for my  
Covid 19 Awareness and  
Health Care Workers with

aring Protocol would be  
entions in our department.  
tudy period. The protocol  
ified participants.

at only for the completion

## Appendix K

### Consent Form



**Philippine Heart Center**

**Institutional Ethics Review Board**

8/F Medical and Arts Building

East Avenue, Quezon City, 1100, Philippines

Tel. /Fax no.: 9252401 loc.3899; Email address: irbphc@gmail.com

#### **PATIENT INFORMATION AND INFORMED CONSENT FORM**

IERB NUMBER	
PROTOCOL NUMBER	
SITE OF STUDY <i>Lugar ng Pag-aaral</i>	Philippine Heart Center, East Avenue, Quezon City
TITLE OF STUDY <i>Pamagat ng Pag-aaral:</i>	Effect of Watson's CARE (COVID 19 Awareness & Related Experience) Program to reduce anxiety level of Health Care Workers isolated due to COVID 19 at Philippine Heart Center
LANGUAGE <i>Wika:</i>	<i>Tagalog</i>
SUBJECT'S NAME <i>Pangalan ng Kalahok</i>	
NAME OF INVESTIGATOR <i>Grupo ng Tagapanaliksik</i>	Jane Ivah P. Ongpauco, RN

<p>ADDRESS OF INVESTIGATOR</p> <p><i>Address ng Grupo ng Tagapanaliksik</i></p>	<p><i>Philippine Heart Center</i></p> <p><i>East Avenue, Quezon City</i></p>
<p>CONTACT NUMBER</p> <p><i>Telepono at iba pang detalye sa pagkontak</i></p>	<p>0917-847-7818</p>

**1) Participation**

You are being considered to participate in a research study about the Effect of Watson’s CARE (COVID 19 Awareness & Related Experience) Program to reduce anxiety level of Health Care Workers isolated due to COVID 19 at Philippine Heart Center. Before you can take part in this study, it is important that you understand what the study involves. Please read this information carefully and ask any questions that you might have. The Philippine Heart Center Institutional Ethics Review Board (PHC

Effect of Watson’s CARE (COVID 19 Awareness and Related Experience) Program to  
 Reduce Anxiety Level of Health Care Workers Isolated due to COVID 19 at Philippine Heart  
 Center

IERB) has reviewed the purposes of the study and has given a favorable opinion of it.

### 1) **Pakikilahok**

*Hinihilingan kang makilahok sa isang pananaliksik tungkol sa bisa ng Watson's CARE (COVID 19 Awareness & Related Experience) Program sa antas ng pagkabahala ng mga pasyenteng may COVID19 sa Philippine Heart Center. Bago ka makilahok sa pag-aaral na ito, mahalagang maintindihan mo kung ano ang nakapaloob sa pag-aaral na ito. Mangyaring basahin nang mabuti ang impormasyon at magtanong ka ng anumang nais mong itanong. Ang Philippine Heart Center Institutional Ethics Review Board (PHC IERB) ang nakapagrepaso sa mga layunin ng pag-aaral at nakapagbigay ng mabuti palagay tungkol dito.*

### 2) **Purpose of the Study**

The purpose of the study is to measure the Effect of Watson's CARE (COVID 19 Awareness & Related Experience) Program to reduce anxiety level of Health Care Workers isolated due to COVID-19 at Philippine Heart Center.

### 2) **Layunin ng Pag-aaral**

*Nilalayan ng pag-aaral na ito na alamin ang bisa ng Watson's CARE (COVID 19 Awareness & Related Experience) Program sa antas ng pagkabahala ng mga pasyenteng may COVID19 sa Philippine Heart Center*

### 3) **Approximate Number of Participants and the Expected Duration of Your Participation in the Study**

The study will take place at Philippine Heart Center. About 64 or more participants will be enrolled to participate in the study. Participants must meet all the qualifications to be included. If you are enrolled, the duration of your participation is fifty to sixty (50-60) mins.

### 3) **Humigit-Kumulang na Bilang ng mga Kalahok at Inaasahang Tagal ng Iyong**

## **Pakikilahok sa Pag-aaral**

*Ang pag-aaral ay isasagawa sa Philippine Heart Center. Humigi't kumulang animnapu't apat (64) ang ililista sa pag-aaral. Para makasali, dapat matugunan ng kalahok ang lahat ng kwalipikasyon. Kapag ikaw ay napabilang sa mga kalahok, ang iyong pagsali ay inaasahang tatagal ng limampu hanggang animnapung (50-60) minuto.*

### **4) Study Treatments and Procedures**

If you agree to be in this study, you will be asked to do the following things: (1)

#### **4) Mga Pamamaraan ng Pag-aaral**

*Kung ikaw ay sasangayon sapag-aaral na ito, ikaw ay inaasahang gawin ang mga sumusunod: (1)*

### **5) Benefits**

The benefit of your participation is to provide Watson's CARE (COVID 19 Awareness & Related Experience) Program to help lessen anxiety level of Health Care Workers isolated due to COVID 19 at Philippine Heart Center.

### **5) Mga Benepisyo**

*Ang benepisyo ng pag-aaral na ito ay makapag bigay ng Watson's CARE (COVID 19 Awareness & Related Experience) Program upang mabawasan ang pagkabahala ng may COVID19 sa Philippine Heart Center.*

### **6) Risk**

The study will not impose any physical or mental harm to the respondents as it will only test the effectiveness of the program to lessen the anxiety level of Health Care Workers isolated due to COVID 19 at Philippine Heart Center. There may be foreseeable risk of discomfort due to environmental temperature, inconvenience and extent of the activity.

## **6) Mga Panganib**

*Ang pag-aaral na ito ay walang pisikal o mental na panganib na maibibigay sa mga kalahok dahil ito ay magsususi lamang ng epiktibong paraan para mabawasan ang pagkabahala ng mga pasyenteng ng may COVID19 sa Philippine Heart Center. Maaring magkaroon ng nakikitang panganib dahil sa temperatura ng kapaligiran, abala at bigat ng gawain.*

## **7) Compensation**

You will not be paid for participating on this study.

## **7) Kabayaran**

*Kayo ay hindi makakatanggap ng kahit anong kabayaran sa pag-aaral na ito.*

## **8) Voluntary Participation / Withdrawal from the Study**

Your participation in this study is voluntary. It is up to you to decide whether to take part or not. If you choose not to participate in this study, you are free to refuse, and it will not interfere with your future care. If you join the study and change your mind later, you may withdraw from the study anytime by informing the researchers, and this will not affect your health care.

## **8) Kusang-loob na Pakikilahok / Pag-alis mula sa Pag-aaral**

*Kusang-loob ang pakikilahok mo sa pag-aaral na ito. Nasa iyo ang desisyon kung makikilahok ka o hindi. Kung ayaw mong lumahok sa pag-aaral, ikaw ay maaring tumanggi at hindi nito maaapektuhan ang pangangalaga sa iyo. Kung sumali ka sa pag-aaral at nagbago ang isip mo, maari kang umalis sa pag-aaral sa pamamagitan ng pagsasabi sa mga mananaliksik at hindi nito maapektuhan ang pangangalaga sa kalusugan mo.*

## **9) Permission for Review of Records, Confidentiality and Access to Records**

Your participation in this study will be anonymous. We will not be collecting or retaining

any information about your identity. This information, called data, will be entered without your name, on a report form. All the data collected will be kept confidential and will be used only as permitted by the consent form.

#### **9) Permiso sa Pagrepaso ng mga Talaan, Paglilihim at Pagkuha sa mga Talaan**

*Ang iyong pagkakakilanlan ay mananatiling lihim Hindi kami mangongolekta o magiiwan ng mga impormasyon tungkol sa kasarinlan ng kalahok.. Ang impormasyong ito na tinatawag na datos ay ipapasok sa isang data collection form nang wala ang iyong pangalan. Papalitan ng code ang iyong pangalan sa lahat ng mga data collection forms. Lahat ng datos na nakolekta ay pananatilihing lihim at gagamitin lamang hanggang sa ipinahihintulot ng kasulatang ito.*

#### **10) Questions/Information**

If you or your representative(s) have any questions regarding the study, you should contact your study researcher: **Jane Ivah P. Ongpauco, Phone number: 09178477818.**

If you or your representative(s) have any questions regarding your patient rights as they relate to the study, you should contact **Dr. Marcelito Durante**, Chair of the Institutional Ethics Review Board of the Philippine Heart Center, East Ave., Quezon City, Philippines, Tel: 92524011oc. 3899.

#### **10) Mga Katanungan/Impormasyon**

*Kung ikaw o ang iyong kinatawan/mga kinatawan ay mayroong anumang katanungan tungkol sa pag-aaral (o kung sakaling may mga kapinsalaan kaugnay sa pag-aaral, kung ang pag-aaral ay may eksaminasyon o ibibigay na interbensyon o gamot), ang iyong kakausapin ay si **Jane Ivah P. Ongpauco, Phone number: 09178477818***

*Kung ikaw o ang iyong kinatawan/mga kinatawan ay may katanungan tungkol sa iyong*

*mga karapatan bilang pasyente kaugnay sa pag-aaral, ang iyong kakausapin ay si **Dr. Marcelito Durante**, Chair of the Institutional Review Board of the Philippine Heart Center, East Ave., Quezon City, Philippines, Tel: 9252401 loc. 3899.*

### **11) Consent Signatures**

Please read this section carefully and if in agreement please sign and date at the bottom of the page.

- I have been provided the details of the known or foreseeable side effects and risks of the research medication and study procedures that I may receive.
- I understand that I am free to accept or refuse my participation at any time without giving a reason. My decision to accept or refuse my participation will have no effect on my continuing treatment. I understand that I am free to discontinue my participation at any time without giving a reason. My decision to discontinue my participation will have no effect on my continuing treatment. I will keep all my rights to treatment and alternative therapy.
- I agree that the data collected for the study will be used for the purpose described above.
- I will not lose any rights that I have under local law by signing and dating this form.
- I have read and understood the information presented in this Informed Consent Form. I have been given the opportunity to ask questions and all my questions have been answered.
- I will receive a signed and dated copy of this Informed Consent Form.

### **11) Mga Pirma ng Pagsang-ayon**

*Basahin nang mabuti ang bahaging ito at kung sumasang-ayon ka ay mangyaring pirmahan at isulat ang petsa sa huling bahagi ng kasulatang ito.*

- *Ibinigay sa akin ang mga detalye ng mga maaaring di mabuting epekto at mga panganib ng gamot ng pananaliksik at mga pamamaraan ng pag-aaral na maaari kong matanggap.*
- *Nauunawaan ko na kusang-loob ang aking pagsang-ayon o pagtanggì sa pakikilahok sa anumang oras nang walang ibinibigay na kadahilanan. Ang desisyon ko sa pagsang-ayon o pagtanggì sa pakikilahok ay walang epekto sa patuloy na paggagamot sa akin. Nauunawaan ko na may karapatan akong ihinto ang aking pakikilahok anumang oras nang walang ibibigay na kadahilanan. Ang desisyon kong huminto sa aking pakikilahok ay walang magiging epekto sa patuloy kong paggagamot. Mananatili ang aking mga karapatan sa ibang paggagamot at mapagpipiliang paggagamot.*
- *Sumasang-ayon ako na ang mga impormasyon na makukuha para sa pagaaral na ito ay gagamitin para sa layunin na inilarawan sa itaas.*
- *Hindi mawawala ang anumang karapatan na mayroon ako sa ilalim ng batas sa pagpirma ko sa form na ito.*
- *Nabasa ko at nauunawaan ang impormasyong iniharap sa Ipinaalam na Kasulatan ng Pahintulot na ito. Binigyan ako ng pagkakataon na makapagtanong tungkol dito at pawang nasagot lahat ang aking mga katanungan.*
- *Ako ay makakatanggap ng kopya ng pirmado at may petsa na Informed Consent Form/Pahintulot.*

**12) I FREELY ACCEPT TO PARTICIPATE IN THIS STUDY /**

**KUSANG-LOOB NA TINATANGGAP KO ANG PAKIKILAHOK SA PAGAARAL  
NA ITO**

Sign and date at the same time, all party:

*Pirmahan ng sabay-sabay, (hal. parehong petsa), nang lahat ng kasali:*

**Printed Name of Participant**

*Isinatitik na Pangalan ng Kalahok*

---

**Date (to be entered by the participant)**

*Petsa (isusulat ng Kalahok)*

---

**Signature**

*Lagda*

---

**Printed Name of Study Personnel Obtaining Consent**

*Isinatitik na Pangalan ng Kawani ng Pag-aaral na humihingi ng Pahintulot*

---

**Date**

*Petsa*

---

**Signature**

*Lagda*

---

Distribution: original for researchers, copy to \_\_\_\_\_(name of participant)

*Pamamahagi: ang orihinal para sa mga tagapanaliksik, kopya para kay \_\_\_\_\_(pangalan ng kalahok)*

For emergency situations where consent of the participant cannot be obtained the following signature line must be signed:

*Para sa mga sitwasyong 'emergency,' kapag di makuha ang pahintulot ng kalahok na pasyente ay nararapat idagdag ang sumusunod na linya ng pirma*

**Printed Name of Participant's Legally Authorized Representative**

*Isinatitik na Pangalan ng Legal na Kinatawan ng Kalahok/ Pasyente*

---

**Date (to be entered by participant's Legally Authorized Representative)**

*Petsa (isusulat ng legal na kinatawan ng Kalahok)*

---

**Signature**

*Lagda*

---

**Relationship to Participant**

*Kaugnayan sa Pasyente*

---

If the participant's legally authorized representative cannot read, the following signature line should be signed:

*Kapag ang legal na kinatawan ng kalahok/pasyente ay hindi nakakabasa, nararapat idagdag ang sumusunod na linya ng pirma:*

**Printed Name of Witness**

*Isinatitik na Pangalan ng Saksi*

---

**Date (to be entered by the witness)**

*Petsa (isusulat ng Saksi)*

---

**Signature**

*Lagda*

---

At any given time, an incapacitated adult (e.g. intubated patients, unconscious patients, or patients in emergency situations, or patients with impairment in decision making) may explicitly refuse to participate in or request to be withdrawn from the study. The Investigator must respect the request. Wherever possible, the patient will be informed as soon as possible, and his/her consent will be requested for the continuation of participation to the study.

*Sa kahit na anong oras, ang isang kalahok na may limitasyon sa paggawa ng desisyon sa pagsali (e.g., intubated patients, walang malay na pasyente, pasyenteng nasa emergency room, pasyenteng may limitasyon sa pagdedesisyon) ay maaring tahasang tumangging lumahok o makiusap na umurong sa pagsali sa pag-aaral na ito. Kailangang igalang grupo ng tagapanaliksaik ang pakiusap. Kung kailangan, sasabihan sa lalong madaling panahon ang pasyente at hihingin ang kanyang pahintulot para makapagpatuloy sa paglahok sa pag-aaral na ito.*

**CONFORME:**

---

*Mananaliksik*

---

*Date*