The art of nursing: An evaluation of congruence of nurse-patient perceptions of the healing interaction

Gillian Yvonne Dargan-Doxzon

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THE ART OF NURSING: AN EVALUATION
OF CONGRUENCE OF NURSE-PATIENT
PERCEPTIONS OF THE HEALING
INTERACTION

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Nursing

by
Gillian Yvonne Dargan-Doxzon

June 2011
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ABSTRACT

The aim of this study was to ascertain the possibility of using a survey tool to measure the congruence of the perception of the healing interaction between nurse and patient using characteristics that represent the art of nursing, those being: presence, compassion, openness, respect, trust, and empathy.

Patient satisfaction with hospital services has gained much attention by hospital administrators and patient safety advocates since the inception of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reporting mandates by government agencies. Four elements of HCAHPS ask the patient to indicate how often nurses “a) treated you with courtesy and respect, b) listened carefully, c) explained things and, d) responded to call lights.” HCAHPS does not measure treatments or nursing procedures. Therefore, the HCAPS survey does not address nursing technical competency, but the art of nursing, i.e., caring. Hence, it is important for hospitals to be able to evaluate and measure caring attributes, including whether patients perceive that those attributes occur during nurse-patient interactions.

iii
Utilizing a convenience sample of six registered nurses were paired with assigned patients and were surveyed regarding the perception of the nurse-patient interaction. The surveys were paired for congruence between the patient perception and the nurse perception of the same interaction.

The findings are consistent with the existing literature in that patients perceive nurse-patient interactions more positively than do nurses themselves. However, attention to the personal needs of patients and perception of lack of compassion on the part of the patient, are the concerns most commonly reported. These factors should be addressed when trying to improve and evaluate the nurse-patient interaction.

The study, although limited in size, yielded results similar to those of larger studies and patient satisfaction surveys currently used by the Centers for Medicare and Medicaid. There is limited research found regarding the importance of nurses' presence at the bedside in the United States. Therefore, future qualitative and quantitative studies should provide a greater emphasis in nursing research on the nurse-patient interaction. Further, exploration on the definition and demonstration of the art
of nursing should be pursued by the profession, as a whole, in order to continue improving quality and caring for and about patients.
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First, I would like to acknowledge the support of Dr. Teresa Dodd-Butera, who with her dedication and time kept my aspirations alive to complete this project; and of Dr. Mary Molle, for initiating the focus for the study instruments; and my third reader Susan McGee-Stehsel. Equally important, my gratitude to Redlands Community Hospital administration and the clinical nursing team for their willingness and support to have this study be a part of their focus in transitioning into their new model for patient centered care.

Importantly, I would like to recognize the silent contributors—the patients and family members whose hugs, handholding, tears and joy, showed me how relationship-centered nursing care could mean so much. To the late Mrs. Smith, I would like to say: Little did you know, when you pulled that eighteen-year-old student nurse aside and asked her to “Please come, my husband is dying,” how strongly it would embed ‘the art of nursing’ into my nursing care. With only two weeks’ experience, I had few clinical skills to offer—I could take a blood pressure reading—but you showed me that the perception of a “nurse” standing beside you, helping you suffer the moment, meant everything to
you. You taught me why the art of nursing is so very important. Forty years later, I can still remember clearly the room where you were standing and how little I felt I had to offer. How wrong I was, for it mattered to you that I gave you "nursing presence" and comfort care.

I also want to thank those family members and friends who allowed me to be involved in their most vulnerable experiences and, from a different perspective, to hear about or witness how the lack of the art of nursing negatively affected your care. Therefore, to you, Rene, Tracey, Ken, and Gladys—your less than optimal moments gave me the drive to address this elusive caring theme and hopefully address the essence of what needs to be enhanced in nursing care today.

Finally, I would like to acknowledge my two beautiful daughters, Samantha and Jennifer. Now peers, as registered nurses, they will continue my work, in striving for optimal patient care.
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CHAPTER ONE

BACKGROUND AND SIGNIFICANCE

Introduction

Nursing is an art; and if it is to be made an art, it requires as exclusive devotion, as hard a preparation, as any painter's or sculptor’s work. For what is the having to do with dead canvas or cold marble compared with having to do with the living body—the temple of God's spirit? It is one of the fine arts; I had almost said the finest of the fine arts. (Nightingale, 1969, p. 504)

After more than one hundred years, how does today’s nursing profession define the art of nursing? Moyer (2008) refers to the art of nursing as “aesthetic or knowing how” (p. 35). Fingeld-Connet (2008) found that the nursing literature has not been able to define the meaning of “the art of nursing,” saying that attributes such as relationship-centered practice, and the skill to practice within the ‘art’ of caring, change as expertise in practice develops.

Today, the focus on the nurse-patient relationship falls under auspices of “patient-centered care,” a focal
point reported by the Institute of Healthcare Improvement (IHI) to assist hospitals and other providers in improving the quality of healthcare in the U.S.

In 1995, the American Nurses Association added to its definition of nursing, “a need for a provision of a caring relationship” (Baily, 2009). To have this caring relationship, a nurse needs to communicate well; it is one of the basic elements of nursing competencies (Bowles, Mackintosh, & Torn, 2001).

Arnold and Boggs write that “caring” occurs when the nurse is, “fully and uniquely present with another human being” (2003, p.121). Others define the art of nursing as a nurse’s ability to assess more than what is said verbally, to “read between the lines” of what patients are saying (Jarrett & Payne, 1994). The art of nursing is more commonly referred to today as “intuitive or aesthetic” knowledge (Jackson, Clements, Averill, Zimbro, 2009).

According to Leonard et al. (2004), “communication failures are an extremely common cause of inadvertent patient harm.” In the assessment of sentinel events (serious harm to or death of a patient), The Joint Commission (TJC) reports that communication failure is one of the key elements found when performing a root cause...
analysis during the investigation of medical errors (TJC, 2010). Therefore, the focus of improving hospital communication has become a paramount campaign, nationally and internationally, for improving patient safety (Hamilton & Martin, 2007; Laschinger, Hall, & Almost, 2005).

Nursing care is provided as a 24-hour-a-day continual care practice. Therefore, it is difficult to isolate individual nurse practices when analyzing aggregate data of groups such as patient care surveys. Patients in acute care facilities will have different nurse caring for them daily, and from shift to shift; the patient care surveys report the patients’ perception retrospectively and as a single episode of care. Therefore, it is difficult for nurse executives to determine which nurse or support staff (e.g., nursing assistant) provided the care that did not meet the patients expectations.

To improve communication, and thereby improve patient satisfaction and safety, in 2002 The Centers for Medicare & Medicaid Services (CMS), in collaboration with Agency for Healthcare Research and Quality (AHRQ), designed the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (The survey was given its final format in December 2005.) The primary reason for the HCAHPS survey is
to provide a uniform survey instrument and data collection method to measure the patients’ perspectives of hospital care (CAHPS overview, 2011). The aggregate data from the HCAHPS surveys is managed by the Centers for Medicare and Medicaid (CMS); and the data from HCAHPS are compiled from participating hospitals (ones that receive funds for federal programs like Medicare and Medicaid. The data is available online for the public to use as a reference when selecting a hospital for services at the CMS website (www.hospitalcompare.hhs.gov). The survey contains eighteen elements for the patient to evaluate the care they received. The eight key elements are:

(1) Communication with physician,
(2) Communication with nurses,
(3) Responsiveness of hospital staff,
(4) Pain management,
(5) Communication about medicines,
(6) Discharge information,
(7) Cleanliness of the hospital environment, and
(8) Quietness of the hospital environment (HCAHPS Survey Instrument, Appendix D).

The Joint Commission also performs evaluations of competency in healthcare communication during the hospital
accreditation process - they survey approximately "ninety percent of all U.S. hospitals" (Blackmond, n.d., p. 3). The revised 2011 Joint Commission standards include specific measurements for improving patient-centered communication in the hospitals. To assist hospitals in meeting these enhanced standards, the Joint Commission since August 2010 has provided a free monograph titled *Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care during Treatment* (Zhani, 2010).

Due to this substantial change in focus to patient-centered care, patient satisfaction has become a success measurement and leading indicator of perceived quality in healthcare today (Lovgren, Sandman, Engstrom, Norberg, & Eriksson, 1998, p. 33). The literature shows that, while the government and private surveys companies such as Press Ganey and NCR Picker, measure overall nursing communication perceived by the patient, the surveys do not measure the congruence of perception of the nurse-patient interaction. Hence, only patients' experiences, expectations, and perception of care are surveyed (Messner, 1993, p. 38).
Statement of the Problem

Doona et al. (2007) state, “neither the value of registered nurses’ presence, nor the danger of nurse absence, is considered during the hospital budgeting process.” This issue brings up the question of how nurse-patient relationships are valued, or how they relate to patient outcomes (Finch, 2005).

Surveying patients regarding their perceptions of care is subjective in nature (Drain & Clark, 2004). The examination of congruence between nurses’ and patients’ perceptions is important to measure (Hanson, 2004), as research shows that nursing care is the strongest predictor of overall patient satisfaction during a hospital visit (Laschinger, McGillis Hall, & Almost, 2005, p. 220). Even though the way a patient regards his or her care is “only” a matter of perception, the fact remains that for that particular patient the perception is the reality (Drain, 2004).

Therefore, it is critical for hospitals to understand the components of nurse communication. The evidence shows that while, on the one hand, patients long for better connections with nurses, on the other hand they believe that nurses are too overworked and/or overwhelmed to be
able to provide more focused therapeutic relationship, thereby meeting patients’ expectations (Shattell, 2004).

Therapeutic communication is a core element of all nursing training. Currently, however, there is no formal evaluation of whether nurses master this communication skill (Jarrett & Payne, 1994).

In the HCAHPS survey, the “nursing communication” section does not indicate to the patient whether they are evaluating a registered nurse or other nursing departmental staff. Therefore, when the patient is asked how well the nurse communicated, whether they were treated with dignity, and so forth, it is left to the patient to determine who or what personnel is being evaluated in the survey (HACAPS survey Appendix D). Hence, not all data gathered regarding nursing care can be sorted to reflect whether the successes or challenges were by registered nurses, licensed vocational nurses, or unlicensed assistive personnel.

Competent patient interaction and communication is difficult to evaluate or measure, as the nurse must establish a human-to-human relationship ("caring about," not just "caring for") to be able to ensure the comfort of the patient (Henderson, Van Eps, Pearson, James, & Henderson, 2007). In addition to the intimate relationship
focus of nursing care, there are also many variables affecting perception, such as pain, fear, the patient’s clinical condition, and the nurse’s workload and competency (Waldow, 2009). Constructive feedback from the patient regarding his or her perception of the level of the nurse’s care can assist the nurse in evaluating the quality of the one-on-one interactions with the patient (Laschinger et al., 2005).

Maureen Bisagnano, executive vice president and chief operating officer of the Institute for Healthcare Improvement (IHI), states that “nurses are crucial to closing quality-of-care gaps” (Bisagnano, 2010, p. 84). Therefore, it is critical that nurse researchers discover ways to measure the competence of nurses in their interactions with patients.

**Purpose of the Study**

Because the safety of patients is multi-faceted, many organizations are researching what affects patients’ perceptions of good care. Yet the literature review shows that the individual relationship between nurse and patient, at the one-on-one relationship, which Doona et al. (1997)
refer to as "being there" and "being with," has not been extensively researched (Attree, 2001).

Therefore, the purpose of this study is to pilot a new tool that encompasses both patients' and nurses' perceptions of the nurse-patient interaction. This pairing of surveys will measure the congruence of the perceptions between the nurse and the patient. The use of the tool will show the potential feasibility of measuring the one-on-one nursing interaction in the acute care setting and potentially identify further research to be evaluated measuring this important facet of nursing competency and further improving the quality of patient-centered care (Robinson, Callister, Berry, & Dearing, 2008).
The Art of Nursing an Overarching Principle

The term ‘overarching principle’ means a principle that is all-embracing and comprehensive (“overarching,” 2009); the art of nursing is also all-embracing and comprehensive. Caring, presence, openness, compassion, empathy, trust, respect are just a few terms that are cited in the literature when referring to the art of nursing (Andrus, 2010; Baily, 2009; Beck, 1999; Belcher & Jones, 2009; Bisognano, 2010; Carper, 1978; Henderson et al., 2007).

Much of the literature uses ‘caring’ as an inclusive term for many of the positive attributes that nurses should have. Arnold and Boggs define ‘caring’ as a nurse being “fully and uniquely present with another human being” (Arnold & Boggs, 2003, p. 121). However, caring—the art of nursing—is now more commonly referred to as intuitive or aesthetic knowledge (Jackson et al., 2009).

How can the nurse affect patient perception? Beck (1999) explains that the act of caring is “not only
complex, an elusive concept to define, but is also
difficult to measure". Basic communication is part of the
art of caring, and nursing communication is more than
transference of words (Firth-Cozens & Cornwell, 2009).
Communication, in the broad sense (verbal, non-verbal), is
a core element and an integral part of the basic training
that in the United States there has been limited research
of student nurse-patient communication in the clinical
setting, and that often the students had difficulty in
applying the learning to the real life situations (p. 63).

A nurse has to be open to participating in this
patient relationship by using excellent listening skills
allowing for competent interpretation of information
received from patients and other healthcare team members,
because healthcare is a relationship based upon openness,
mutual agreement, and inclusion, which creates genuine
dialogue (Friedman, 2008) and allows the nurse to be
intuitive.

Intuitiveness allows the nurse to recognize unspoken
cues, such as discomfort, anxiety, or sadness. Much of the
literature refers to this as "compassionate care" or
"aesthetic knowing" (Carper, 1978). Clinical nursing
intuitiveness is a skill that is learned through experience, and professional expertise relies on such intuitiveness when using clinical reasoning to assess and determine the plan of care for a patient (McCutcheon & Pincombe, 2001, p. 347). When evaluating experience, nursing research shows that rarely is the nurse’s competence in communication formally evaluated (Jarrett & Payne, 1994, p. 73).

To communicate and thereby successfully care for patients, the nurse must be able to anticipate and understand the needs of each patient as an individual (Balik, Conway, Zipperer, & Watson, 2011). Papastavrou, Efstathiou, Charalambous, (2010), after reviewing many studies that used quantitative methodologies, such as the Caring Behavior Inventory (CBI), the Caring Behavior Assessment (CBA) and the Caring Dimensions Inventory (CDI), concluded that there is little congruence of patient and nurse perceptions about what constitutes caring behaviors.

Theoretical Framework

The initial framework for the development of this study’s survey tools came from another survey tool created to “Quantifying the Healing Relationship,” which was
designed to “evaluate nursing students’ competencies to provide interhuman healing”, and based upon Martin Buber’s theory of dialogical psychotherapy and the healing interaction (Molle, 2005).

Peplau

Peplau’s Human Interaction Theory was a good framework for the evaluation of the nurse-patient interaction survey tool, as it helps define a formal structure for the relationship between the nurse and the patient (Arnolds & Boggs, 2003).

Phases of Communication in Peplau’s Theory

Orientation. When the client needs and seeks professional assistance, the nurse enables the patient to recognize and understand the existing health concern.

Identification. The patient identifies the helping source, and the nurse explores the medical condition and how the patient feels, then supports the patient in coping with the disease process and outcomes.

Exploitation. Is where the patient can gain full value from the services offered in the nurse-patient relationship. The nurse can put forth new goals for the patient to aim for, hence shifting power from the nurse to the patient.
Resolution. Patient replaces old goals with new ones, becoming independent from the nurse and moving towards sustainable outcomes. (See Arnold & Boggs, 2003, Chapter 5.)

The I-Thou Relationship

Friedman (2008) explains Buber’s theory this way: “What is essential is not what goes on within the minds of the partners in a relationship but what happens between” (p. 298). This concept merges well with the nurse-patient congruence aspect of this study.

Communication

In Stephen Covey’s world-renowned book, The 7 Habits of Highly Effective People, Habit Number Five is “Seek first to understand, and then be understood. By enacting this, the communicator will listen with intent to understand others rather than with the intent to reply and therefore true communication can occur” (Covey, 2003, p. 14). Practice by the nurse using this method is a crucial element of a successful nurse-patient interaction (Davis, Foley, Crigger, & Brannigan, 2008).

Healthcare communication is expected to be therapeutic in nature. Such communication occurs when the nurse helps
steer the interaction with the patient, allowing them to work together in (a) promoting positive outcomes, (b) understanding the clinical plan for the day, and (c) during education for the patient (Arnold & Boggs, 2003, p. 19)

In 1999, the Institute of Medicine (IOM) published the White Paper, "To Err is Human." This report brought forward serious concerns regarding patient safety in acute care facilities across the United States. Research shows that patient safety issues were, at best, "only discussed within the confines of the hospital administration team"; and that preventable adverse events (negative outcomes for patients that could have been avoided) are a leading cause of death in the United States (IOM, 1999, p. ix). The journey to improve healthcare quality in the United States began in 1998 when the Institute of Medicine’s Quality of Healthcare Committee was created. Its goal was to create a template to improve quality in patient care services over a ten-year period. In 1999, the Robert Woods Johnson Foundation and the Institute for Health Improvement (IHI) coalesced to create a program, initially known as the “100 Thousand Lives Campaign,” which now is referred to as the “5 Million Lives” (Protecting 5 million lives brochure).
One of the recommendations of the IOM White Paper was that there should be a mandatory national reporting system to collect information regarding adverse events that result in death or serious harm (IOM, 1999, p. 9).

In 2002, The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Agency for Healthcare Research and Quality (AHRQ), designed a hospital consumer assessment of healthcare providers and systems known as the HCAHPS. This assessment tool forwards internal measures of medical errors from participating hospitals to the data collection site for CMS. Additionally, surveys rating patients’ perception of the care they received while in a hospital was to be sent to CMS. Hospitals that do not participate in HCAHPS survey (and receive federal reimbursement for providing care) will receive a 2% reduction in the annual reimbursement of care rendered for Medicare and Medicaid inpatients ("HCHAPS," 2008, p. 5).

The primary reason for the HCAHPS public reporting system is to provide a repository for reporting and comparing hospital data, so that the consumer of hospital services is able to make comparisons between hospitals and the care provided ("HCHAPS," 2008). The data from the
HCAHPS surveys is located on the website of the Centers for Medicare and Medicaid (www.hospitalcompare.hhs.gov).

The Joint Commission for Accreditation (TJC) of Hospitals surveys most of the hospitals in the United States. In their 2011 Accreditation Manual, the Commission identifies the elements of competent healthcare communication, whether between patients and nurses, or nurses and other healthcare providers.

TJC’s new program standards for improving communication is supported by a booklet called *Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Care during Treatment* (JCH 2010), which further establishes the importance of the nurse communication role.

Failure in communication, whether by an act of omission or misinterpretation, is one of the leading causes of healthcare errors, affected millions of lives (Nieva & Sorra, 2003). Soafer and Firminger (2005) report that asking patients’ to identify elements of quality healthcare, and important aspects of communication by healthcare providers, is an important issue for studying the aspects of care delivery.
Patient satisfaction has become one of the leading indicators for evaluating quality in healthcare (Lovgren, Sandman, Engstrom, Norberg, & Eriksson, 1998, p. 33). To succeed in improving patient satisfaction, the healthcare team must elicit excellent communication and interpersonal skills (Ervin, 2006, p. 129; Robinson, Callister, Berry, & Dearing, 2008).

'Satisfaction' does not necessarily imply high-quality clinical care, and therefore is a relative concept based upon patient perception (Drain & Clark, 2004). However, in 2012, CMS will be using the percentile patient perception rankings (not just hospital participation as it is now) from HCAHPS survey to allocate funds to hospitals (Hospital Case Management, Nov 2010). The HCAHPS survey asks patients to reflect on the care they received; the accumulation of patient perception regarding nursing care is reported in the aggregate data titled “How often did nurses communicate well with patients?” (HCAHPS Fact Sheet, 2010).

**Nurse Communication**

Argyris’s (1968) theory of competence acquisition suggests that "if participants have opportunities to diagnose their interpersonal competence, they can increase
their interpersonal competence” (Fosbinder, 1994, p. 1091). It is not only in patient surveys that patients’ find an avenue to report concerns with nurse communication. Challenges in communication, identified as a major concern of patients (Shattell, 2004, p. 714) can also be found reported as informal commentary through patient advocate websites such as The Quality Patient Experience website (www.quality_patient_experience.com.)

Wilkinson, Linsell, and Blanchard (2008) piloted a project evaluating a three-day communication skill course, where nurses’ communication skills were evaluated pre- and post-training. The findings show that the course appeared to make the nurses more confident in their communication skills. However, no patient perception was included as part of the study, to validate that the patient, as the receiver of the communication felt that there had been improvement in the nurses’ skill (Wilkinson, Linsell, & Blanchard, 2008)

The 2009 nationwide aggregate data reviewing hospital care found on the CMS website (www.hospitalcompare.hhs.gov), show that patients gave a score of only 75% for “excellence” in nurse communication, meaning that 25% of patients surveyed felt that their
communication with the nurse was less than optimal. Research validates that poor personal communication in the workplace is the number one barrier for optimal patient care in hospitals (Orlovsky, 2005). Additionally, communication was the most frequently cited cause of medication errors in 1995-2003 (Patterson, Cook, Woods, & Render, 2004).

**Patient Challenges to Communication**

The majority of adult patients belong to the generation known as the “traditionalists” (those born between 1927 and 1945), with “baby boomers” (those born between 1946 and 1964) a close second (Lowe & Skarl, 2009). Therefore, it is important for nurses to evaluate cultural implications of aging patients when addressing patient interactions and communication (TJC, 2010). According to the National Institute of Deafness and other Communication Disorders (NIDCD), 1 in 3 patients over the age of 60 have a significant hearing deficit. Along with hearing, vision deficits are well known to be a part of aging and these two deficits together can create patient safety challenges, as significant decrease in visual function greatly affects a patient’s ability to function independently; together these
concerns become a major factor in successful healthcare communication (Arnold & Boggs, 2003).

Kruijver et al. (1999) found that patients in the care of a nurse who received additional training in communication skills had less anxiety than those cared for by nurses without focused communication training. Why is this important? Elevated anxiety levels in patients diagnosed with a myocardial infarct (heart attack) are 4.9 times more likely to have complications with ischemia (low blood flow) and other cardiac arrhythmic complications (Moser, 1996).

Nurse-Patient Interaction Studies

"The absence of nursing presence leaves patients feeling depersonalized and alone" (Doona et al., 1997, p. 5). Moreover, Leebov (2008) confirms, "without a positive nurse-patient relationship, there cannot be patient and family satisfaction; and there cannot be an environment that supports anxiety reduction and healing." Both these statements support the importance of nursing presence.

The IHI identified the results of increasing nursing to patient interaction by just thirty minutes per patient day improve clinical outcomes (IHI, 2010, p. 87). However,
McIlveen and Morse (1995) report that, because of increased patient acuity, aspects of caring and comforting are seen as a secondary focus in today’s bedside nurse (Hanson, 2004). The literature shows that nurses spend the least amount of their clinical time in the actual presence of the patient (Andrews, '2010).

The HCAPS survey contents show that it is the caring aspect that patients measure when completing their satisfaction surveys, as patients expect their nursing staff to be clinically competent. They therefore rate the care they received in terms of how the nurse made them feel, not on how well the tasks are performed (Attree, 2001; Rupp Wysong & Driver, 2009). Jarret & Payne’s (1994) study found that nurses believed they need more training in communication, and are often too busy to have quality nurse-patient communications.

In a study of thirty-six hospitals, nurses spent only 15% of their workday on direct patient care activities, excluding medication administration, paperwork, or care coordination (IHI, 2010). However, when discussing patient scores, “many nurses see customer service strategies as false and resent the surveys’ focusing on the nurse behavior” (Leebov, 2008, p. 21). Carayon and Gurses (2008)
asked whether hospital administration personnel considered the patient’s clinical condition and barriers to care when evaluating effective staffing patterns and nurse workload during budgetary design for unit staffing. However, in the State of California, the concern about appropriate staffing levels above ratio guidelines is meant to be addressed by using acuity-based staffing models, but the American Nurse Association reports that “54% of nurses in adult medical units and emergency rooms do not have sufficient time with patients” (NursingWorld website, n.d.).

Laschinger, Hall & Almost (2005), evaluated twenty-nine instruments used to measure patient satisfaction (as it relates to nursing quality of care). For their study, an adaptation of the Patient Judgment of Hospital Quality (PJHQ) was developed. The new tool, Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ), is a nineteen-element list of nursing activities that patients use to measure and rate their perceptions of how well the nursing staff performed. This study analyzed the group measurement of nursing staff, and did not distinguish between the registered nurse from other nursing department employees, (e.g. nursing assistants), or how the nursing
interaction correlated with the individual patient experience (Lashinger, 2006).

Henderson et al. (2007) performed an exploratory study in 2005 observing thirty-nine nurse-patient interactions for twelve four-hour periods, over a four-week timeframe. In addition to the observation, surveys were mailed to patients who were discharged from the same medical-surgical unit during the four-week period. (The study does not make clear whether the patients in the observation phase were the same as in the surveyed patients.) The aim of the research was to ascertain the patients’ perceptions of the nurse-patient interactions. The assumption by the researcher in this study is that when nurses have meaningful relationships with their patients they will recognize and address the patient’s concern and improve patient satisfaction. The results of the study showed that while the data collectors frequently witnessed “friendly interactions,” “expert compassion” skills were seen the least.

The most common negative comments by patients in Henderson’s study were grouped into a category named “Nurse Forgetfulness” (e.g., not returning to remove a patient’s bedpan or saying “Yes” to a patient’s request and not
completing the task they agreed to perform for the patient). Additionally, the authors report that routine conversations with patients consisted of informing and instructing them (e.g., medication information, activities of daily living, explanation of aspects of treatment). However, during these short interactions, the nurses failed to explore concerns voiced by the patients which the researchers of the study felt depicted patients were “cared for” not “cared about” (Henderson et al., 2007).

Caring is a difficult attribute to measure and there is much debate from nursing theorists whether its measurement should be qualitative or quantitative (Beck, 1999, p. 24). Fosbinder’s (1994) qualitative study of 40 patients and 12 nurses viewed 240 videotaped interviews of nurse-patient interactions. The findings show that when patients talked about the nurse-patient interaction, they focused on interpersonal competence, not on clinical skills. This finding was supported by Attree’s (2001) study of what patients believed made a nurse a “good nurse.”

In both studies, patients identified providing care beyond minimal expectations as the nurse “going the extra mile.” However, neither authors measured the congruence with how the nurse perceived the interaction. Fosbinder
reports that a lack of reciprocal evaluation of the nurses’ interpretation of the encounter during the study was a limitation, and recommends that future studies include the measuring of employee’s interpersonal competence (p. 1091).

Uitterhoeve, Bensing, Dilven, Donders, & deMulder (2008) report that during their study on nurse-patient communication, nurses’ ability to respond to patients’ cues were independently found to relate to increased patient satisfaction (p. 1060). A nurse has to be present with the patient to assess the cues or nonverbal nuances; however, nurses complain that increasing workloads due to the nursing shortage, overtime, and reduced lengths of stay all affect nurses’ ability to spend quality caring time with their patients (Carayon & Gurses, 2008).

Throughout the literature, the terms ‘presence’, ‘compassion’, ‘openness’, ‘empathy’, ‘respect’, and ‘trust’ are said to be present when the nurse has a caring approach toward clients; and Peplau describes nursing presence as not merely meeting the patient needs but focusing on the nurse-patient relationship. (Crawford, 2010, p. 16). Studying individual perception is a very difficult aspect of nursing research, and the studies show that the patient and nurse perception of what is caring are not in
congruence (Laschinger et al., 2005). Most of the nursing research regarding the "art of nursing", found during the literature review for this thesis, was represented in phenomenological and qualitative studies or editorial discussions. The quantitative aspects focused primarily on the demographic aspects of the study.

Hospital Consumer Assessment of Healthcare Providers and Systems

The Agency for Healthcare Research and Quality (AHRQ) explains that the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) may be similar to other patient satisfaction surveys except that, instead of asking patients to rate their experience on a 1-5 scale, they are asked to indicate how frequently a behavior occurred (Always, Usually, Sometimes, or Never). (See Appendix D.) Additionally, HCAHPS scores are considered "more specific, actionable, understandable, and objective" ("HCAHPS overview," 2011, p. 2).

Leaders in the field of performance improvement strongly recommend that hospitals use the data from the HCAHPS results as a way of finding the root causes of specific quality concerns ("Use patient satisfaction data to zero in on areas for improvement," 2010).
The HCAHPS survey results from the Center for Medicare and Medicaid website for April 2009-March 2010 show that in the category of “Nurse Communication,” the hospital scored a 71% for the nurse always communicating well. “Communicating well” is described as the nurse explaining things clearly, listening carefully and showing courtesy and respect. The score at the hospital was slightly lower than hospitals nationally, which are rated at 76% (Appendix E). Currently, there are no studies available in the literature evaluating the results of HCAHPS, or the congruence of perceived good care and improved clinical outcomes (Robinson et al., 2008).

California State of Healthcare

The California Healthcare Foundation website shows the distribution of chronic conditions in California (Figure 1). In 2007, 36% of California adults were reported to have at least one chronic health condition (asthma, congestive heart failure, diabetes, hypertension, or psychological distress).

Cardiovascular Disease

According to the American Heart Association (AHA) statistical update 2010, one in three Americans have a
diagnosis of one or more heart related conditions. The California HealthCare Foundation reports that in 2007 there were half a million Californians diagnosed with congestive heart failure (CHF). San Bernardino County is reports a 32% of the population in the county are diagnosed with CHF.

**Chronic Obstructive Pulmonary Disease (COPD)**

In the United States, the Center for Disease Control (CDC) reports that in 2000, almost ten million adults had a diagnosis of COPD, and the disease is the fourth leading cause of death in the United States (MMWR, 2007).

**Diabetes mellitus**

The California HealthCare Foundation reports that in California there are two million adults with diabetes, of these 34% were sixty-five or older; in San Bernardino County; the number reported is that one hundred and twenty seven thousand people have diabetes (Lui, 2010)
CHAPTER THREE

METHODOLOGY

Introduction

The aim of the study was to test a new tool for measuring the congruence of the nurse-patient interaction between the registered nurses and patients, in order to find a quantitative method for measuring the attributes of the art of nursing.

Survey Design

An evaluation tool designed to evaluate student nurses competencies, titled Quantifying the Healing Relationship, (Molle, 2005) was the used for the development of a survey tool for this study. The framework of Dr. Molle’s tool was adapted into a new tool to measure the congruence between nurse and patient perception during a nurse-patient interaction.

After evaluating all the data and information gathered from the literature review, input from peers, hospital representatives, and faculty at California State University, San Bernardino (CSUSB), the revised survey tools were created (See Appendix C). The nurse-patient
interaction survey was simplified to have basic communication characteristics that would be easily understand by both patients and registered nurses.

**Pilot Test**

The revised tool was piloted in a student nurse class setting. The students received instruction on what the basic elements of the study were, and how the study was to be performed. After reviewing the results of the pilot test and making revisions, the new tool was sent to the hospital for approval for use in the study.

A quantitative methodology shows patterns and trends, where qualitative methods allow for interpretation during open-ended interviews or direct observation. As this study's intent was to evaluate a survey tool, it was critical to have both forms of data collection, so that patient and nurse perceptions, impressions, recommendations for improvement, and other comments regarding the use of the tool could be collected and evaluated.

**Study Setting**

The study site hospital was a community hospital located in southern California. The top types of admissions to the hospital are seen in Table 1 below, and matched the
patient population intended to be used for the study. The community hospital is located in the east portion of the Inland Empire (IE). The IE is comprised of cities located in Riverside County and San Bernardino County (See Figure 1). The IE is designated as an urban area and is the fifth largest in California as of the 2000 census. The 2006 census also showed that the city of Redlands (study town) has a total population of 70,382, a 10% gain since 2000 (US census bureau).

Figure 1. Inland Empire-Southern California Map
Table 1. Top Admission Type - Study Hospital (CMS, 2009)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maternity Care</td>
</tr>
<tr>
<td>2</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>3</td>
<td>Total knee replacement</td>
</tr>
<tr>
<td>4</td>
<td>Sepsis</td>
</tr>
<tr>
<td>5</td>
<td>Cardiac (Heart Failure)</td>
</tr>
<tr>
<td>6</td>
<td>Appendectomy</td>
</tr>
<tr>
<td>7</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
</tbody>
</table>

Participants

Patients

This population was limited to patients with medical conditions of heart failure, chronic obstructive pulmonary disease, or diabetes mellitus. This was because chronic complex illness patients generally have a history of frequent admissions, and therefore may have extensive experience regarding nurse-patient interactions. Other requirements for the inclusion in the study were that patients' pain level should be no more than a scale of five.
(ten being unbearable), that they be cognitively intact (i.e., able to comprehend the spoken word and conceptual nature of the study), and be able to read and speak English. This was an IRB-approved study, with consenting Nurse-Patient pairings (see Appendix A for IRB approval and consent form).

Registered Nurses

Registered nurses (RNs) caring for medical telemetry patients (those who require electronic heart monitoring) were invited to participate after their patient consented to participate. If a nurses’ patient declined to participate, the nurse was excluded; to further clarify patients who were on telemetry but required intensive care level of nursing; were also excluded.

Telemetry units were selected for the research project. These are adult units where the patient-to-nurse ratio is 1 licensed nurse to 4 patients. One of the telemetry units provides nursing care by a team structure whereby there is a Registered nurse and licensed vocational nurse assigned to manage the care of the patients jointly according to their appropriate scope of practice. The other telemetry unit does not use a team approach and staffs with all RNs.
Study Methods

In preparation for the on-site study, a PowerPoint presentation, giving a brief overview of the study, was sent to the participating hospital. This was distributed to the nurse managers of the units included in the survey. These managers sent a synopsis of the study by email to the registered nurses in their units.

The nurse researcher collected the data and arranged to spend two days administering the survey at the hospital site. Each morning, the researcher met with the charge nurses on the units to identify patients who met the pre-determined criteria (see Appendix A). Once patient selection occurred, the nurse researcher toured the unit, and decided to wait until a morning assessment and other RN tasks had been performed prior to going to each patient.

At the appropriate time (not to interrupt care-giving or visiting by physicians), patients were asked to consent to an interview. Participation by the patient was voluntary and confidential. The data collector gave a verbal explanation of the study, ensured anonymity, then showed the forms to the patient, after which the consent to participate was signed (Appendix B).
During the interview, the patient was asked to complete the “Patient Survey Tool,” measuring the perception of the interaction of the nurse and the patient. Patients were given a copy of the “Descriptions” page, which explained the terminology on the survey tool (Appendix C). Patients then had the opportunity to complete the form independently or to have the data collector describe the ratings for them, and to make any additional comments. Patients then completed the survey in the presence of the data collector in case there was any further need for clarification of the intent of study.

Once the survey was complete, the researcher asked each patient, “Is there anything additional you would like to add about your encounter or your nurse today?” If the patient wished to make additional comments, he or she was asked to write them on the survey sheet or the information was scribed for them verbatim even if the patient did not answer the actual intent of the question, but gave other information instead.

After the patient interaction, the assigned registered nurse for that particular patient was given the option to participate in the study by completing the “RN Survey Tool,” evaluating her perceptions of the interaction. If
the nurse agreed, the RN was asked to sign a consent form and was given a copy of the “Definitions” page and the survey tool. Sometimes this happened immediately after the interview with the patient; at other times it was delayed until the nurse was available. All participation was voluntary and confidential, and the analysis would not include identifiable information.

Data Analysis

After completion of each survey, the data collection tools and all materials were gathered by the researcher and not available for review by participants. The raw scores for the survey tools and demographic were analyzed by categories (key characteristics and demographic elements) for both patients and nurses.

The researcher paired the responses for evaluation of congruence in the measurement of the interaction between nurses and patients. The intent was not to grade whether the interaction was positive or negative, but to determine whether patients and nurses both perceived their interaction the same way.

The free commentary made by patients or nurses was evaluated for frequency of similar comments and reported
independent of the quantitative responses. Patient responses that could not be paired with a nurse response (due to nurse declination to participate) were included in the raw data and eliminated in the congruence measurements.

Responses were graded on a five-point scale using an adaptive "Wong-Baker" faces scale (faces 5 - 1 represent how the patient or nurse perceived the interaction).

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>☺</td>
<td>☺</td>
<td>??</td>
<td>☹</td>
<td>☹</td>
</tr>
</tbody>
</table>

Figure 2. Adapted "Wong-Baker" Scale
CHAPTER FOUR

RESULTS

The original study design featured a survey of approximately 35 patient-nurse pairs; however, the hospital census and the medical condition of the in-patient population were variables that could not be controlled, and the number was lower than expected. Only 14 patients identified by the charge nurses met the criteria for inclusion in the study. Three surveys were completed by patients whose nurse declined to participate; therefore, those patient scores could not be paired for congruence.

Demographics

Patients

Thirteen out of the fourteen patients had more than one previous hospitalization related to their chronic condition. Seven patients were over the age of 70, two were over 60, two were over 50, and two were over 40; however, age was not selected as a demographic element for measuring congruence in the study data evaluation. All patients selected met the pre-determined clinical criteria(chronic
medical condition, pain lower than a 5, cognitively intact and understands written English) as outlined in the methodology section; all participating patients were cognitively intact, had one or more chronic medical condition, and were able to comprehend the tool and descriptions of the key characteristics. Out of the fourteen patients who met criteria, 85.7% had cardiovascular conditions (such as heart failure). This number tallies with the national figure for patients admitted to acute care facilities.

Two of the patients surveyed were admitted for COPD exacerbation and had no other co-morbidities. All of the patients with diabetes had cardiovascular disease.
Table 2. Patient Characteristics

<table>
<thead>
<tr>
<th>Characteristics of patients surveyed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 70+</td>
<td>7</td>
</tr>
<tr>
<td>Age 60+</td>
<td>3</td>
</tr>
<tr>
<td>Age 50+</td>
<td>2</td>
</tr>
<tr>
<td>Age 40+</td>
<td>2</td>
</tr>
<tr>
<td>Gender M/F (n 5/9)</td>
<td>36% M/64% F</td>
</tr>
<tr>
<td>Cardiac history w/ DM (n 11)</td>
<td>79%</td>
</tr>
<tr>
<td>COPD history (n3)</td>
<td>21%</td>
</tr>
</tbody>
</table>

Nurses

Six registered nurses participated in the study (one RN declined). Five were associate degree nurses and one had a baccalaureate degree in nursing and was a new graduate on the all-RN telemetry unit of the hospital. All but one of the participating nurses had been employed at the hospital for less than five years. Further analysis also showed that four nurses had been there less than one year, and that three of the four were new graduates in 2010. The “outlier” RN (> 20 years in practice) was a per diem (not regular full-time or part-time employee) nurse who had worked at the hospital for eight years and who holds a non-clinical
registered nurse position, on a full-time basis, at a different facility.

Table 3. Nurse Characteristics

<table>
<thead>
<tr>
<th>Characteristics of Nurses Surveyed (n = number of RN’s)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Degree RN (n = 5)</td>
<td>83%</td>
</tr>
<tr>
<td>Bachelor Degree RN (n = 1)</td>
<td>17%</td>
</tr>
<tr>
<td>Years as RN – &gt; 20 years of experience</td>
<td>1</td>
</tr>
<tr>
<td>Years as RN – 2-4 yrs of experience</td>
<td>2</td>
</tr>
<tr>
<td>Years as RN – new graduate (less than one year experience)</td>
<td>3</td>
</tr>
<tr>
<td>Overtime worked by nursing staff (# RN)</td>
<td>1</td>
</tr>
<tr>
<td>Telemetry Unit versus Step-Down Unit (3/3)</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Data Collection**

**Patient Data Collection**

During the patient data collection, the interview of twelve patients began with the patient talking about the nurses as a group (rather than the individual RN who was assigned as their primary care nurse). These patients began discussing the RN care using the word “they.” The patient was reminded by the data collector to evaluate the one RN assigned to care that day. This nurse was further
identified as the nurse who “examined you and hung your intravenous medication.” The data collector verified with the primary care nurse that she was indeed the nurse performing the tasks, to ensure that the correct nurse was identified for the pairing. Additionally, some patients looked towards their “white board,” located on the wall, to find the name of their nurse, but did not know which one was the RN versus the LVN (this occurred on the unit that had the team model for care). The same reminder (nurse who examined you and hung your intravenous medication) was used for them to be able to assess the correct nurse for the survey.

All fourteen patients surveyed agreed that the nomenclature of the elements to measure (presence, compassion, openness, respect, trust, empathy) were qualities that a nurse should possess when caring for a patient. Several patients also mentioned friendliness, kindness, and attentiveness as qualities they liked to see in a nurse. The “Descriptions” laminated page was available for the patient to read during the survey (see Appendix B). Ten out of fourteen patients (71.4%) who completed the survey gave a score of “5” (best score possible) to all nurse-patient interaction characteristics. This matches the
study site's hospital ratings in HCAHSP in the category "How often did nurses communicate well with patients?"

Table 4 shows that the less than optimal scores were reported by two of the fourteen patients, of whom one was male (50+ yrs) and one female (60+ yrs). For these two patients, the data suggests that presence, compassion, openness, and empathy of their nurses were perceived as less than expected. However, these two patients perceived that there was optimal respect and trustworthiness.
Table 4. Patient Perception of Interaction Characteristics

<table>
<thead>
<tr>
<th>Patient</th>
<th>Presence</th>
<th>Compassion</th>
<th>Openness</th>
<th>Respect</th>
<th>Trust</th>
<th>Empathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>B</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>C</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>D</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>E</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>F</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>G</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>H</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>I</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>J</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>K</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
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<td>5</td>
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<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Open Commentary by Patients

Thirteen patients, during the free commentary section, mentioned that their nurse was “so busy” that they (the patient) understood why call light response and IV pump attention was not as rapid as they would have liked. The
comments made by patients regarding the nursing care showed a pattern of patients, stating the nursing staff was "excellent," that "all are good," and that the nursing staff frequently reminded the patient to use the call bell if they had any needs.

One registered nurse, mentioned by name by more than one patient, was said to have "that old-fashioned quality that makes you feel as if they really care." Other unsolicited comments made by patients were not as positive. These comments focused on the nurse being too busy to respond to intravenous pump alarms, or pain medicine requests in a timely manner. Additionally, there were five patients, who said they had not had baths for forty-eight hours or longer.
Table 5. Patient Open “Comment” Section of the Survey Tool

<table>
<thead>
<tr>
<th>Patient Concern</th>
<th>Number of patients reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses are too busy to respond to patient needs. Most frequent term used by patient “They are so busy”</td>
<td>13</td>
</tr>
<tr>
<td>No bathing opportunity offered by staff, however it was not clarified whether “wipes” were offered</td>
<td>5</td>
</tr>
<tr>
<td>IV Alarms not answered in a timely manner. Complaints of keeping patient awake at night and annoying at other times</td>
<td>6</td>
</tr>
<tr>
<td>Inability of patient to identify RN from LVN in the team model, prior to researcher explaining nursing responsibilities and tasks.</td>
<td>10</td>
</tr>
</tbody>
</table>

**Nurse Data Collection**

Of the six registered nurses participating in the study, five were associate degree nurses, and one had a baccalaureate degree in nursing. All but one registered nurse had been at the hospital for less than five years; four were there for less than one year (three of the four were new graduates in 2010). The seasoned RN (>20 yrs experience) was a nurse who had worked at the hospital for eight years and holds a non-clinical registered nurse
position, on a full-time basis, was the only nurse reporting overtime for that current pay period. On the telemetry unit, a registered nurse and licensed vocational nurse deliver care as a team; therefore, some nurses had more than one of their patients surveyed. The pairing of nurse and patient surveys resulted in six nurse-patient interaction comparisons. One telemetry nurse declined to participate. This particular nurse said she did not have time to complete the survey. A stamped addressed envelope was left for her to mail her survey; however, no survey was received. Therefore, there were three valid patient surveys, which could not be matched to a nurse survey for congruence.
Table 6. Nurse Perception of Interaction

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Presence</th>
<th>Compassion</th>
<th>Openness</th>
<th>Respect</th>
<th>Trust</th>
<th>Empathy</th>
<th>Yrs RN</th>
<th>Degree/unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN1:</td>
<td>Pt C</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>&gt;20</td>
<td>ASN/tele</td>
</tr>
<tr>
<td>RN1:</td>
<td>Pt D</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>&gt;20</td>
<td>ASN/tele</td>
</tr>
<tr>
<td>RN2:</td>
<td>Pt B</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4 (5)</td>
<td>5</td>
<td>2-4</td>
</tr>
<tr>
<td>RN2:</td>
<td>Pt H</td>
<td>5</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>5</td>
<td>2-4</td>
</tr>
<tr>
<td>RN3:</td>
<td>Pt F</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>5</td>
<td>4 (5)</td>
<td>&lt;1</td>
</tr>
<tr>
<td>RN3:</td>
<td>Pt G</td>
<td>5</td>
<td>4 (5)</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4 (5)</td>
<td>&lt;1</td>
</tr>
<tr>
<td>RN6:Pt</td>
<td>Pt J</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>3 (5)</td>
<td>4 (5)</td>
<td>&lt;1</td>
<td>ASN/step down</td>
</tr>
<tr>
<td>RN6:Pt</td>
<td>Pt K</td>
<td>4 (5)</td>
<td>3 (5)</td>
<td>4 (5)</td>
<td>4 (5)</td>
<td>3 (5)</td>
<td>3 (5)</td>
<td>&lt;1</td>
</tr>
</tbody>
</table>

Nurse responses when grading the interaction with the patient, on a 5-point scale using an adaptive "Wong-Baker" face scale. (Scores in gray mean that the patient scored interaction lower than did the nurse.)

Nursing Open Commentary Option

Only one RN made any additional comments on the self-evaluation survey. She gave herself a score of three on the
presence attribute, and noted "patient on dialysis," indicating that dialysis was performed in the patient's room. No other comment was made and therefore no opportunity to clarify what was meant by this statement.

Congruence of Data Elements

To review, the elements measured were the nurses' presence, compassion, openness, respect, trust, and empathy. The following tables (Tables 7-9) show the congruence or lack of congruence between the patient and nurse assessments. "RN1" (the nurse with > 20yrs experience) was the only nurse to be in congruence of perception with both of her patients. The highest cause of lack of congruence was found within the new graduate nurse population surveys. There the patient rated the nurse-patient interaction higher than the nurse rated it, most notably in the areas of presence, openness, and trust. As Belcher and Jones (2009) found during their study, new graduates believe that their lack of technical skills will create a lack of trust on the part of the patient. In Table 7, below, the most noteworthy figure is the lack of congruence in compassion and empathy. This agrees with
the findings in Henderson et al.'s (2007) study, whose observation of nurse-patient interactions indicated that nurses were perceived as lacking compassion.

Table 7. Congruence between Patient and Nurse Perception

<table>
<thead>
<tr>
<th>Art of Nursing Characteristic (n = number of encounters)</th>
<th>Congruence % Patient/Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence</td>
<td>46% (n5)</td>
</tr>
<tr>
<td>Compassion</td>
<td>27% (n3)</td>
</tr>
<tr>
<td>Openness</td>
<td>46% (n4)</td>
</tr>
<tr>
<td>Respect</td>
<td>46% (n5)</td>
</tr>
<tr>
<td>Trust</td>
<td>55% (n6)</td>
</tr>
<tr>
<td>Empathy</td>
<td>37% (n4)</td>
</tr>
</tbody>
</table>

Table 7 shows the number of time that patients rated the qualities of interaction higher than the nurses did.
Table 8. Patient Perception Higher

<table>
<thead>
<tr>
<th>Art of Nursing Characteristic (n 11 encounters)</th>
<th>Times patient rated nurse higher than nurse perception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>Compassion</td>
<td>6 (55%)</td>
</tr>
<tr>
<td>Openness</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>Respect</td>
<td>5 (45%)</td>
</tr>
<tr>
<td>Trust</td>
<td>5 (45%)</td>
</tr>
<tr>
<td>Empathy</td>
<td>5 (45%)</td>
</tr>
</tbody>
</table>

Below, Table 9 shows the number of times when the nurse perceived the interaction more positively than did the patient, except in the area of trust, where there was congruence.
Table 9. Nurse Perception Higher

<table>
<thead>
<tr>
<th>Art of Nursing characteristic</th>
<th>Times nurse rated herself higher than patient perception (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence</td>
<td>1 (9%)</td>
</tr>
<tr>
<td>Compassion</td>
<td>2 (18%)</td>
</tr>
<tr>
<td>Openness</td>
<td>2 (18%)</td>
</tr>
<tr>
<td>Respect</td>
<td>1 (9%)</td>
</tr>
<tr>
<td>Trust</td>
<td>0</td>
</tr>
<tr>
<td>Empathy</td>
<td>2 (18%)</td>
</tr>
</tbody>
</table>

None of the surveys showed scores indicating a dissatisfied (#2) or very dissatisfied (#1) interaction. Due to the low volume of data and a convenience sampling in the study, there were too few data points to create inferential statistical information.
CHAPTER FIVE

DISCUSSION, LIMITATIONS, CONCLUSION

Introduction

Research has shown that patient perception of care is a critical factor evaluated in the healthcare industry today. (Robinson, Callister, Berry & Dearing, 2008). In 2013 (using 2012 performance data), there will be financial penalties levied on hospitals, under the guidelines of the Patient Protection and Affordable Care Act of March 2011 (Studer, 2010). There is controversy in the healthcare industry as to the value of patient perception surveys and some question as to whether it really impacts quality of care provided to patients (Leebov, 2008; Hanson, 2004). The IHI states in Achieving and Exceptional Patient and Family Experience of Inpatient Hospital Care, that some healthcare workers believe (falsely) that there is no evidence proving that patient and family-centered care is effective (p. 5).

Additionally, there is also discussion as to the expenditure of the resources used to perform the studies as it is estimated to cost the hospital approximately $11 to $15 per survey. Questions arise as to could whether that
money is better spent by adding additional nursing staff, which has proven to improve patient satisfaction and clinical outcomes? (Ervin, 2006; Lovgren, Sandman, Engstrom, Norberg, & Eriksson 1998; Patterson, Cook, Woods, & Render 2004; IHI 2010; Uitterhoeve, Bensing, Dilven, Donders & deMulder, 2008; Clark, Leddy, Drain & Kaldenberg, 2007)

Whether it is to improve patient satisfaction scores ergo patient perception of care, or patient clinical outcomes, the literature review shows that nurses must be proficient in communication and be aware of the importance of nursing presence to create a safe and successful nurse-patient interaction (Kruigver et al., 1999; Moser, 1996; Orlovsky, 2005; Arnold & Boggs, 2003; Henderson, 2007; Fosbinder, 1994; Finch, 2005; Fingeld-Connet, 2008). In addition, to have high-quality and safe care there must be effective nurse-patient interaction, because communication failures are reported to be a leading cause of patient harm (Leonard & Bonacum, 2004).

Doona, Haggerty & Chase (1997) emphasize, "nurses know that their presence, sometimes more than their techniques, is essential to caring for their patients." Bisagnano (2010) believes that "nurses are crucial to closing
quality-of-care gaps.” Yet, studies have shown that very little time is actually spent in the presence of the patients in the medical-surgical units of hospitals. This was the experience that the nurse research found during this study, although “time in the room” measurement was not a part of the data collection elements.

Discussion of Findings

The structure of the study tool closely resembles surveys (e.g. HCAHPS, Press-Ganey & NCR Picker) currently in use for measuring patient satisfaction, by using a Likert-scale format (Drain & Clark, 2004; Burns, Aydin, Donaldson, Brown, Nelson, Harms, 2003). There were no comments that the tool was difficult to follow conceptually, therefore, the survey tools appears easy to use. The free commentary section proved important to have as part of the survey, as the open commentary focused on the patients’ personal needs that were not met; these concerns could affect survey results for HCAHPS or internal patient surveys (Shattell, 2004).

The nursing demographics section of this study showed that the more experienced nurse’s evaluation of the congruence paired well with her patients’ perceptions. This
is consistent with the findings of Amendolair (2007) and Benner (1984) that experienced nurses are more competent in self-assessment. The less experienced nurses seemed more uncomfortable in rating the interactions; and that new graduates consistently rated the perception of the interaction lower than the patient rated the same interaction. This is consistent with the findings of Soafer and Firminger (2005), which showed nurses with less than two year experience consistently rate themselves lower than the patients perception. Furthermore, the high rating of the interaction by patient may validate findings in the literature that patients regard the interpersonal skills of a nurse more highly than the nurses’ technical skills (Rupp Wysong & Driver, 2009). Additionally, the literature reports that new graduate nurses do not feel their care is valued as high by patients, compared to the experienced nurse. The literature identifies a need for improved communication skills in the professional setting (Bowles, 2001). With the aging workforce approaching retirement, consideration must be given to how hospitals plan to address the mentoring of new nurses, as discussed in Wagner and Seymour’s continuing education article “A model of Caring Mentorship for Nursing” (2007).
Thirteen out of the fourteen patients gave as the reason for lack of environmental or personal attention the nurses "being too busy" to be able to meet the patient's needs. This supports McIlveen and Morse's (1995) findings suggesting that caring and comforting are not a nursing priority, as caring for high acuity patients is focused on technology not aesthetic patient needs (Hanson, 2004). In addition, Corbin (2008) remarks that in the essence of fighting for professional recognition the nurse no longer value the hands-on therapeutic touch that occurs during bathing or ambulation. The literature review also demonstrated that some hospital administrations might not value the time nurses spend in the presence of their patients, or the nature of nurse-patient interaction, as key components in improving patient satisfaction and clinical outcomes (Carayon & Gurses, 2008). Possibly, this is because measuring the art of nursing is said to be elusive (Beck, 1995).

In this study, only one nurse—the experienced nurse—was working overtime hours, and the perceptions of her interactions with the patient were optimal. Some say that nurses working overtime lower patient satisfaction and negatively impacts outcomes, however, not enough studies
have been performed to validate this belief (Bearney & Needleman, 2008).

The measurement of the congruence of nurse-patient interaction has not received adequate study (Merkouris, Ifantopoulos, Lanara & Lemondiou, 1999; Papastavrou, et al 2010). The literature review underscored the importance of the art of nursing, and that it is highly valued by patients (Gallagher, Horton, Tschudin & Lister, 2009). Moreover, there is very little U.S. research regarding the importance of the nurses’ presence at the bedside. Research showed that patient cues (non-verbal communications) and comforting practices (i.e. bathing and ambulation) may be secondary, in the eyes of the registered nurse, to clinical tasks, such as computerized care (i.e. heart monitoring) and documentation, even though the subtle cues (changes in comfort or anxiety) have been found to be the important change in a patient when emergency support teams, in hospitals, have been deployed for a significant change in patient condition (IHI, “rapid response teams” n.d.).

In this study, patients perceived that the nurse-patient interaction was optimal more often than did the nurses. If a nurse feels that his or her patient interactions are less than optimal, questions arise
concerning whether this perception may be the reason for compassion fatigue, turnover rates, and other causes of nurses’ leaving the workforce (Ebert, 2011).

In addition, nursing care surveys show nursing services as group data, not differentiating between licensed nurses and nursing support staff; which can directly influence the validity and value of the survey for assessment of ways to improve patient satisfaction ratings (Drain & Clark, 2004).

Limitations

The main limitation of the research project was the size of the study. Initially, it was designed to have approximately 35 pairs, however, due to patient pre-determined criteria, patient acuity, and nurse volunteers, only 6 pairings were possible. The study was only performed over a single weekend, and could have increased in size had more days been added for data collection.

Additionally, the study did not use any socio-economic information (which in a larger study may have been useful information). Moreover, limiting the study to chronic illness patients may have skewed the data. These patients may have had many admissions and either lowered or elevated
their expectations of nursing care, in comparison to patients who have not had any admission or an admission for a long period of time.

Recommendations

Before the tools utilized in this study can be used effectively in hospitals, additional testing should be performed in a larger study and presumably, the structure will need further refinement to be able to be used effectively in measuring nurse-patient interactions.

Future studies regarding nursing presence and outcomes are needed; and could occur when reviewing sentinel events and integrating nursing presence, or lack of, especially as the IHI reports the nurse spends approximately 15% of their time in the presence of the patient (IHI, 2010).

Conclusion

The purpose of the study was to evaluate a survey tool adding to the body of knowledge in nurse-patient interaction research. The results of this study showed that patients perceive the nurse-patient interaction more positively than do registered nurses; and that personal ‘caring’ (i.e. response to call lights) could be improved.
These findings closely match other survey results regarding patient satisfaction, such as HCAHPS, and NCR Picker and research studies on patient satisfaction that used qualitative interview techniques.

However, the logistics of effectively measuring the one-on-one nurse-patient interaction is difficult (e.g. direct observation or interviewing) related to the amount of resources it would require performing evaluations. More appropriately, the writer believes that the tool could be used in nursing schools, to educate novice nurses on effective therapeutic communication, by studying the student nurse perception to those of the patients in real-time. This would allow the nurse to practice self-assessment.

The focus on the one-on-one interaction and self-assessment in this study adds to the body of knowledge for observation of nurse-patient interactions recommended by nursing researchers (Finch, 2005, p. 21). The intent of measuring nurse-patient congruence is that if there is congruence, or if not, the nurse understands she is perceived differently than intended, there will be improvement in clinical outcomes and patient satisfaction
via patient-centered care, under the overarching principle of the art of nursing.

Therefore, what this research did confirm is the importance of Maurice Friedman’s words, “What is essential is not what goes on within the minds of the partners in a relationship but what happens between them” (Friedman, 2008 p. 298).
APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVALS
October 06, 2010

Ms. Gillian Dungan-Doxzon
Co: Prof. Teresa Dodd-Betera
Department of Nursing
California State University
5500 University Parkway
San Bernardino, California 92407

Dear Ms. Dungan-Doxzon:

Your application to use human subjects, titled "Nurse-Patient Interaction Congruence" has been reviewed and approved by the Institutional Review Board (IRB). The attached informed consent document has been stamped and signed by the IRB chairperson. All subsequent copies used must be this officially approved version. A change in your informed consent (no matter how minor the change) requires resubmission of your protocol as amended. Your application is approved for one year from October 06, 2010 through October 05, 2011. One month prior to the approval end date you need to file for a renewal if you have not completed your research. See additional requirements (Items 1 - 4) of your approval below.

Your responsibilities as a investigator reporting to the IRB Committee include the following 4 requirements as outlined by the Code of Federal Regulations 45 CFR 46 listed below. Please note that the protocol change form and renewal form are located on the IRB website under the forms menu. Failure to notify the IRB of the above may result in disciplinary action. You are required to keep copies of the informed consent forms and data for at least three years.

1) Submit a protocol change form if any changes (no matter how minor) are made in your research prospectus/protocol for review and approval of the IRB before implemented in your research.
2) If any unanticipated/adverse events are experienced by subjects during your research,
3) Too renew your protocol one month prior to the protocols end date,
4) When your project has ended by emailing the IRB Coordinator/Compliance Analyst.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspect of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals which may be required.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, IRB Compliance Coordinator. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7025, or by email at mgilles@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

Best of luck with your research.

Sincerely,

Sharon Ward, Ph.D.
Chair
Institutional Review Board

cc: Prof. Teresa Dodd-Betera, Department of Nursing
September 28, 2010

Gillian Dargan Doxzon, R.N.
9181 Molt River Circle
Fountain Valley, California

RE: Nurse-Patient Interaction Survey

Dear Ms. Dargan Doxzon:

As you are aware the Institutional Review Board Committee held their quarterly meeting on July 12, 2010 and the above-referenced study was presented for review and approval. The committee had requested documentation of hospital administration's approval for the study and a signed confidentiality agreement from you as principle investigator. Those documents have now been received and the committee is now granting permission for you to conduct the survey at Redlands Community Hospital.

This letter will confirm the formal approval by the Institutional Review Board of the Nurse-Patient Interaction Survey as submitted.

Under FDA regulation, this approval will last one year, expiring July, 2010 and you must request re-approval for the next year at least three weeks prior to the expiration date noted above if you wish additional time to conduct the study.

The FDA requires you to notify the Institutional Review Board of any new advertisements or recruiting material, serious adverse events, amendments or changes in the protocol, significant protocol deviations, patient death or termination of the study. Please note that you must submit all protocol amendments and/or advertisements to the Board for review and await a response from the Board, prior to implementing the amendments and/or advertisements. In addition, the Institutional Review Board Committee requests that you submit a summary report of your findings upon completion of the study.

Sincerely,

Emad Ibrahim, M.D.
Chairman, Institutional Review Board Committee

(Signed by Julie Maynard, Medical Staff Coordinator and Liaison to the Institutional Review Board Committee)
Nurse-patient Interaction Study - Gillian Dargan-Doxzon, CSUSB IRB # 09128

PARTICIPANT RECRUITMENT

Participants for this study will be recruited from the nursing staff and adult patient (above eighteen years old) population located at Redlands Community Hospital, Redlands, CA. Participation will be voluntary. The convenience sample of the population will be required to read and comprehend English and the nurse will be a Registered Nurse (RN) employed by the hospital.

PROJECT DESCRIPTION

This is a study of a pilot survey tool designed to ascertain the correlation of experience between patient and nurse dialogue during a single interaction. The reason for this study is to, eventually, develop a tool that can measure the affective domain of clinical nursing as it relates to nurse-patient interaction. The Institute of Medicine via its White Paper "To Err is Human" has initiated, in collaboration with the Institute of Health and Robert Wood Johnson Foundation, a campaign to prevent medical errors from killing patients, 5 Million Lives Campaign. One aspect of the campaign considered to be the key to patient safety is communication. The literature review shows that to have good communication with patient the nurse has to be "Present, Compassionate, Respectful, Open, Trusted and Empathetic." These key indicators are the characteristics to be measured in the survey.

METHODOLOGY

The tool, a survey (1-5 Likert scale), is completed by the RN caregiver and by the patient receiving the care, this entity constitutes a 'pair'. The pairing is the act of the primary nurse being assigned to the patient for that shift. It does not relate to the clinical condition of the patient matching that of the nurse history. For example,
the patient population will have a medical condition of diabetes mellitus, cardiomyopathy (failing heart muscle), or chronic obstructive pulmonary disease (patients may have more than one of the conditions), however the nurse is not required to have a similar condition.

At start of the shift begins, the manager or designee of the proposed units (4100, 5100, 3200, 3400) will give the investigator the names of the nurses and the patients to may be approached to voluntarily participate in the study. The tool is given after the first shift assessment performed by the RN, representing a single episode of nursing care. The nurse will self-assess his/her interaction with the patient, and the patient will assess his/her assessment of the interaction. The Charge Nurse or Nurse Manager will ascertain as to which patients may or may not be asked to participate depending on client condition. This will be one limitation of the study. The survey, which is presumed to take less than ten minutes, will be answered by the patient, should the patient require assistance the principal investigator will be there to assist with the function of asking the question and marking the response via a structured interview. Any open commentary will be literally transcribed in the patient’s words. The medical history will be extracted by the primary care nurse from the patient, via the off-going shift report and electronic medical record.

The survey is anonymous; the nurse and patient will not have the ability of seeing the reports completed by anyone other than their own survey. The tool, has been adapted from an original design for use in counseling (therapist-client relationship), was developed using the theory of Dialogical Psychotherapy using Delphi method to identify eight specific characteristics. Therefore, this project is pilot test of pilot tool, modified for clinical nursing. The pilot survey will identifying concepts or clarifications that need improvement for use in developing a tool for use in other nursing communication studies in the future.

There is only one investigator, who will be on the hospital campus during the survey process. There will be a collection of 35 paired samples. Should there be any non-paired samples, this information will be analyzed as a separate group. The study will be performed on the medical/surgical/telemetry units (4100/5100). The nurse will be identified and selected before the patient. Once
the nurse has agreed to participate then a patient will be randomly selected from her assignment list, any exclusion of patients will be determined by the charge nurse or nurse manager. The patient will be offered the option to participate or decline. The RN will have the option to participate or decline. The investigator will be available for questions. To eliminate variance in interpretation of the Likert scale, the use of “facial expression measurement” (adapted from the Wong-Baker pain scale) has been evoked.

ANALYSIS
The basic characteristic scores on the pilot survey will be correlated using T Test between the nurse and the patient responses. Additionally, other variables will be evaluated to ascertain as to whether any of the demographic data had any additional correlation with the ratings. The open-ended question will be reviewed by the principal investigator for any common themes. The data collected will be retained by Redlands Community Hospital, in a locked file, with limited access by CNO, Director of Education and Director of Nursing, for a period of five years.

CONFIDENTIAL DATA
There will be no collection of personal patient identifiers or nurse identifiers collected. Other demographical data is located on the survey tool.

RISKS AND BENEFITS
Risks: There are no identifiable risks to the patient or the nurse associated with the completion of this survey.

Benefits: There are no immediate benefits to the patient or the nurse. The information gained from the use of the pilot study tool will be able to show, whether the interaction tool can be used successfully or will need further refinement for future studies. The information will gathered will provide a base line for the Hospital, to measure their success following the new program they will be implementing for transforming care at the bedside.

DEBRIEFING STATEMENT
It is not anticipated that there will be a requirement for debriefing of the participants. However, the principal investigator will make time available should question arise.
APPENDIX B

INFORMED CONSENTS
INFORMED CONSENT (Patient)

NURSE-PATIENT INTERACTION SURVEY

We are studying the interaction between nurses and patients to evaluate the congruence (see it the same way) the interaction between you and your nurse. The information will be used to help improve the patient centered care at hospitals. The study is being conducted by Gillian Dargan-Doxon RN, BS, MA, MSN student under the supervision of Dr. Teresa Dodd Butera, Professor of Nursing at California State University San Bernardino. This study has been approved by the Institutional Review Boards of the California State University, San Bernardino and Redlands Community Hospital, Redlands, CA.

There are no know risks if you decide to participate in this survey. Participation is free. The Nurse-Patient Interaction survey will be given to you to complete and to the nurse responsible for your care today. The information collected may not benefit you directly, but the information gathered should provide benefits for future studies on nurse-patient interactions. By completing the questionnaire, you are voluntarily agreeing to participate. You are free to decline to answer any section of the survey.

The survey is confidential. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study. The only demographic information to be collected is your age, gender, pain level, length of stay, diagnosis, and whether English is a primary or secondary language for you; there are no personal identifiers such as your name or medical Record number. The nurse caring for you will not be able to see your results.

If you have any questions regarding this study, please contact Gillian Dargan-Doxon (951) 233-9818 email: dargandel@csusb.edu or tdbutera@csusb.edu. California State University San Bernardino Review Board has reviewed my request to conduct this project. If you have any concerns about your rights in this study, please contact Professor Sharon Ward, Ph.D (909) 537-7304 (909) 537-7028 sward@csusb.edu.

I agree to participate in the above study, and understand that the completion of the survey is my consent to participate. I have had my questions answered.

_________________________________________ 
Signature 

_________________________________________ 
Date 

909.537.5380 • fax: 909.537.7089 • http://nursing.csusb.edu

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2303
INFORMED CONSENT (RN)
NURSE-PATIENT INTERACTION SURVEY

We are studying the interaction between nurses and patients to evaluate the congruence of the interaction from both patient and nurse perspectives. This information will be used to help improve the patient centered care at hospitals. The study is being conducted by Gillian Dargan RN, BS, MA, MSN student under the supervision of Dr. Teresa Dodd-Butera Professor of Nursing at California State University San Bernardino. This study has been approved by the Institutional Review Boards of the California State University, San Bernardino and Redlands Community Hospital, Redlands, CA.

There are no known risks to you, should you decide to participate in this survey. Participation is free and not mandatory. The Nurse-Patient Interaction Tool will be given to you to complete the investigator will be available if you need assistance. The patient/s you are caring for will also do a survey. The information collected may not benefit you directly, but the information gathered should provide benefits for future studies on nurse-patient interactions. By completing the questionnaire, you are voluntarily agreeing to participate. You are free to decline to answer any section of the survey.

The survey is confidential. No one will be able to identify you or your answers, and no one will know whether or not you participated in the study. The demographic information to be collected is attached with this consent. There are no personal identifiers such as Name or Employee number. Your patient or manager will not see your individual survey. The information gathered will be analyzed, and the aggregate data potentially used for further nursing studies or articles. Additionally, the data will be used at the hospital in establishing a baseline and to use in education and training curriculum development.

If you have any questions regarding this study, please contact Gillian Dargan-Donzon (951) 233-9818 email: dargand@csusb.edu, or tbutera@csusb.edu. California State University San Bernardino Review Board has reviewed this request to conduct this project. If you have any concerns about your rights in this study, please contact Professor Sharon Ward, Ph.D (909) 537-7304 (909) 537-7028 sward@csusb.edu.

I agree to participate in the above study, and understand that the completion of the survey is my consent to participate. I have had all my questions answered.

____________________________________ __________________________
Signature Date
APPENDIX C

FINAL SURVEY TOOLS
**Nurse-Patient Interaction Tool - Patient evaluation**  
(Please complete the survey giving your belief of the encounter with your nurse. No information will be shared with the nurse caring for you. All patient information is held confidential. No patient identifiers will be used (e.g. Name or MR#))

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<th></th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<tbody>
<tr>
<td>Presence</td>
<td><img src="image1" alt="Smiley Face" /></td>
<td><img src="image2" alt="Smiley Face" /></td>
<td><img src="image3" alt="Neutral Face" /></td>
<td><img src="image4" alt="Sad Face" /></td>
<td><img src="image4" alt="Sad Face" /></td>
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<td>Compassion</td>
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Is there anything additional you would like to explain about the encounter or your nurse today?

Adapted from:  
Questions about you that will be collected from your nurse.

1. How long have you been on this unit if not originally admitted to your unit which unit did you transfer from?
2. How long have you been in the hospital?
3. Prior admissions to RCH?
4. What is your pain level during this interaction?
   a. What is your admitting diagnosis?
   b. Chronic illness (check all that apply)
      i. Heart
      ii. Respiratory
      iii. Diabetes
      iv. Psychiatric
      v. Other

5. Is English a primary or secondary language for the patient? Primary/Secondary
   a. Patient’s native language ____________________?
6. What is your age?
7. What is your gender?
8. Has the nurse cared for you before today?
### Descriptions for the survey tool

| Presence | With presence, the nurse "shows up" as a whole and authentic person, instead of assuming a role, false self or persona. This term refers to the nurse in an act of "Being a nurse" not just "Doing nursing tasks".  
Did you believe that your nurse was "present" connecting to you, as you received your care? |
| --- | --- |
| Compassion | Being satisfied with your care is associated with the belief that the nurse made an effort to ease your concerns, anxieties, questions and needs.  
Did you believe that your nurse showed compassion to you during your interaction? |
| Openness | Examples of openness are: acceptance, broad-mindedness, impartiality, interest, observance, receptiveness, receptivity, responsiveness, tolerance, understanding  
Did you believe that your nurse had the attributes while caring for you? |
| Respect | Examples of respect are: Listening to your concerns, attended to your immediate needs, and answered your questions or concerns timely.  
Did you believe your nurse was respectful during her/his interaction with you? |
| Trust | Patients have made reference that nurses promote a feeling of trust through attentiveness, competence, comfort measures, dignity, and provision of information. Many patients say the attentiveness of the nurse is important to develop trust.  
Did you feel that there was a trusting relationship with your nurse? |
| Empathy | Unlike sympathy this characteristic is the ability to identify with and understand somebody else's feelings or difficulties while still focusing on the objectives for the day.  
Did you believe your nurse to be empathic? |

Adapted from:
Nurse-Patient Interaction Tool – RN evaluation
Please complete the survey giving your belief of the encounter with your patient. None of your information will be shared with the patient. All information is confidential. No RN identifiers will be used (e.g., Name or license/employee #)

<table>
<thead>
<tr>
<th>Presence</th>
<th>5</th>
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</tbody>
</table>

Is there anything additional you would like to explain about the encounter or your patient?

Survey RN #
Unit #

Adapted from:
Primary Care Nurse (Surveyed nurse):

Please complete the following questions: 

Patient Gender: M/F Age: ___ 
Nurse Gender: M/F Age: ___ 

1. What is the length of stay for this patient on your unit? 
   a. If not originally admitted to your unit which unit did the patient transfer from? 
   b. How long has the patient been in the hospital? 

2. Have you taken care of this patient prior to this survey for this admission? 
   a. How many shifts? 

3. Prior admissions (Y/N)? 

4. What is the current pain level for your patient during this interaction? 

5. What is the admitting diagnosis? 
   a. Chronic illness (check all that apply) 
      i. Heart 
      ii. Respiratory 
      iii. Diabetes 
      iv. Psychiatric 
      v. Other 

6. Is English a primary or secondary language for you? Primary/Secondary 
   a. Your native language? 

7. Is English a primary or secondary language for the patient? Primary/Secondary 
   a. Patient’s native language? 

8. How long have you worked as an RN @ RO? 

9. How long have you worked as an RN? 

10. How many hours have you worked (or are scheduled to work) this pay period? 
    (including hours worked as RN in another facility? 

11. How many hours did you work last pay period (not including this pay period)? 

12. What is your highest degree earned? 
   a. Diploma 
   b. ASN 
   c. BSN 
   d. MSN/MSN 
   e. BS/BA other 
   f. MS/MA other 
   g. PhD/DNP
APPENDIX D

HOSPITAL CONSUMER ASSESSMENT OF
HEALTHCARE PROVIDER
AND SYSTEMS SURVEY
### SURVEY INSTRUCTIONS

- You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- Answer all the questions by checking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:
  - Yes
  - No ➔ If No, Go to Question 1

You may notice a number on the survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

Please note: Questions 1-22 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>During this hospital stay, how often did nurses treat you with courtesy and respect?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>2.</td>
<td>During this hospital stay, how often did nurses listen carefully to you?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>3.</td>
<td>During this hospital stay, how often did nurses explain things in a way you could understand?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>4.</td>
<td>During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td></td>
<td>I never pressed the call button</td>
<td></td>
</tr>
</tbody>
</table>

March 2011
### YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with **courtesy and respect**?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
</tr>
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</table>

6. During this hospital stay, how often did doctors **listen carefully to you**?

<table>
<thead>
<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
</tr>
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</table>

7. During this hospital stay, how often did doctors **explain things in a way you could understand**?

<table>
<thead>
<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
</tr>
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</table>

### THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?

<table>
<thead>
<tr>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
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</table>

9. During this hospital stay, how often was the area around your room quiet at night?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
</tr>
</tbody>
</table>

### YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

<table>
<thead>
<tr>
<th></th>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
</tr>
</tbody>
</table>

12. During this hospital stay, did you need medicine for pain?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

13. During this hospital stay, how often was your pain well controlled?

<table>
<thead>
<tr>
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<th>1</th>
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<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
</tr>
</tbody>
</table>

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

<table>
<thead>
<tr>
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<th>4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
</tr>
</tbody>
</table>
15. During this hospital stay, were you given any medicine that you had not taken before?
  1 □ Yes
  2 □ No  ➔ If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
  1 □ Never
  2 □ Sometimes
  3 □ Usually
  4 □ Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
  1 □ Never
  2 □ Sometimes
  3 □ Usually
  4 □ Always

18. After you left the hospital, did you go directly to your own home, to someone else’s home, or to another health facility?
  1 □ Own home
  2 □ Someone else’s home
  3 □ Another health facility  ➔ If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
  1 □ Yes
  2 □ No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
  1 □ Yes
  2 □ No

OVERALL RATING OF HOSPITAL
Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
  1 □ 0  Worst hospital possible
  2 □ 1
  3 □ 2
  4 □ 3
  5 □ 4
  6 □ 5
  7 □ 6
  8 □ 7
  9 □ 8
 10 □ 9
 10 □ 10  Best hospital possible
22. Would you recommend this hospital to your friends and family?
- □ Definitely no
- □ Probably no
- □ Probably yes
- □ Definitely yes

24. What is the highest grade or level of school that you have completed?
- □ 8th grade or less
- □ Some high school, but did not graduate
- □ High school graduate or GED
- □ Some college or 2-year degree
- □ 4-year college graduate
- □ More than 4-year college degree

25. Are you of Spanish, Hispanic or Latino origin or descent?
- □ No, not Spanish/Hispanic/Latino
- □ Yes, Puerto Rican
- □ Yes, Mexican, Mexican American, Chicano
- □ Yes, Cuban
- □ Yes, other Spanish/Hispanic/Latino

26. What is your race? Please choose one or more.
- □ White
- □ Black or African American
- □ Asian
- □ Native Hawaiian or other Pacific Islander
- □ American Indian or Alaska Native

27. What language do you mainly speak at home?
- □ English
- □ Spanish
- □ Chinese
- □ Russian
- □ Vietnamese
- □ Some other language (please print): ________________________________

THANK YOU
Please return the completed survey in the postage-paid envelope.

[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]
[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

March 2011

APPENDIX E

STUDY SITE HOSPITAL CONSUMER ASSESSMENT
OF HEALTHCARE PROVIDER AND SYSTEMS
SCORES 2010
Patients who reported that their nurses "Always" communicated well. | 71%
---|---
Patients who reported that their doctors "Always" communicated well. | 77%
Patients who reported that they "Always" received help as soon as they wanted. | 55%
Patients who reported that their pain was "Always" well controlled. | 65%
Patients who reported that staff "Always" explained about medicines before giving it to them. | 57%
Patients who reported that their room and bathroom were "Always" clean. | 71%
Patients who reported that the area around their room was "Always" quiet at night. | 49%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home. | 79%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest). | 69%
Patients who reported YES, they would definitely recommend the hospital. | 75%

How often did nurses communicate well with patients?

These results are from patients who had overnight hospital stays from July 2009 through June 2010.

Patients reported how often their nurses communicated well with them during their hospital stay. "Communicated well" means nurses explained things clearly, listened carefully to the patient, and treated the patient with courtesy and respect.

Bars below tell the percent of patients who reported that their nurses "always" communicated well.

How often did nurses communicate well with patients?

- Average for all Reporting Hospitals in The United States: 76%
- Average for all Reporting Hospitals in California: 70%
- Redlands Community Hospital: 71%

How often did staff explain about medicines before giving them to patients?

These results are from patients who had overnight hospital stays from July 2009 through June 2010.

If patients were given medicine that they had not taken before, the survey asked how often staff explained about the medicine. "Explain that hospital staff told what the medicine was for and what side effects it might have before they gave it to the patient."

Bars below tell the percent of patients who reported that staff "always" explained about medicines before giving it to them.

How often did staff explain about medicines before giving them to patients?

- Average for all Reporting Hospitals in The United States: 60%
- Average for all Reporting Hospitals in California: 56%
- REDLANDS COMMUNITY HOSPITAL: 57%

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