Spring 2021

Electronic Medical Records and the Lost Art of Nursing

Tonya Blackwell
tblackwell@gardner-webb.edu

Electronic Medical Records and the Lost Art of Nursing

by

Tonya R. Blackwell

A project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
Master of Science in Nursing Degree

Boiling Springs, North Carolina

2021

Submitted by:	Approved by:
Tonya R. Blackwell, BSN, RN	Tina H. Lewis, DNP, FNP-C
April 27, 2021 Date	April 27, 2021 Date

Table of Contents

List of Figures

CHAPTER I

Introduction

During President Barack Obama's term in 2012, the Patient Protection and Affordable Care Act (PPACA) mandated the use of electronic medical records (EMRs) to take effect in 2014 (Little, 2013). The purpose of the EMR was to give healthcare workers access to a patient record at the click of a button, therefore making the patients' healthcare information more accessible and streamlined with multiple disciplinary team members. Unexpected consequences of the use of EMRs have jeopardized the nurse-patient relationship and therefore the patient satisfaction scores have significantly decreased (Heath, 2007).

Problem Statement

The identified problem within this MSN project was the patient-perceived lack of bedside nursing care while performing tasks with the use of the EMR. The lack of nursing strategies to show a caring attitude to the patient while performing these tasks during the use of EMR are underutilized. Nursing care has become a list of tasks to complete instead of caring for the person (NT Contributor, 2012). It is time to incorporate the lost art of nursing into the current workflow guided by the use of the EMR.

Significance

The Institute of Medicine defines patient-centered care as "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient's values guide all clinical decisions" (Newell & Jordan, 2015). Exactly how does this happen when the nurse is staring at a computer at the patient's bedside? A patient once reported frustration when the nurse entered the room and went straight to the

computer without speaking or even acknowledging the patient (Strauss, 2013). Another patient reported a disconnect with the nurse stating the nurse was focused on something else besides him (Strauss, 2013). There is a breakdown between the patient and the nurse when the nurse makes assumptions about what the patient needs or wants because the nurse did not ask the patient (McCabe, 2004). A positive nurse-patient relationship is vital for the delivery of quality nursing care (McCabe, 2004). When a patient reports they felt like an object instead of a human being because the nurse was focused on a computer in the room instead of them, the caring part of nursing is missing (Strauss, 2013). Electronic medical records may have given access to multiple disciplinary team members at the click of a button, but it also has negative consequences. Patients not only crave attention to be expressed to them in a caring way, but they deserve the respect of being cared for by a nurse and not seen as a task to be completed. The goal of this project was to help nurses not only see the importance of caring but help them incorporate it into their practice. Caring is the lost art of nursing in the world of EMR's.

Purpose

The purpose of this MSN project was to not only present data to the nurse regarding the perceived lack of care while he/she is performing tasks during the use of EMR at the bedside, but also to introduce the nurse to strategies that can show a caring attitude to the patient while performing these tasks during the use of EMR. Nursing care has become a list of tasks to complete instead of caring for the person (NT Contributor, 2012). It is time to get back to the lost art of nursing.

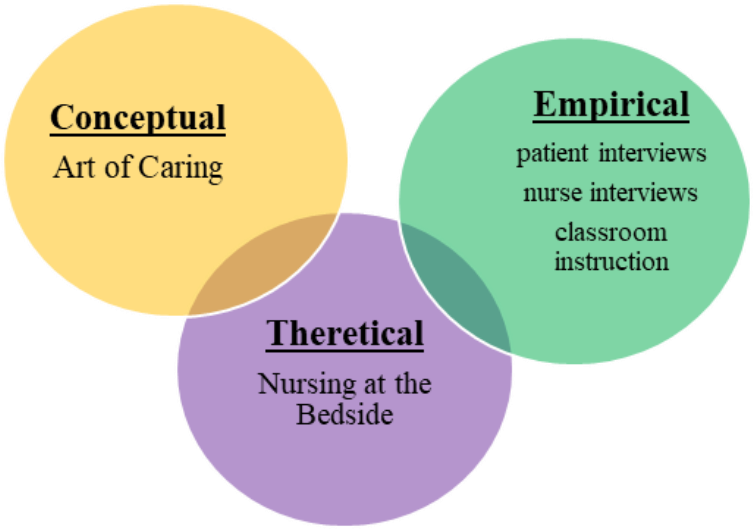
Theoretical/Conceptual Framework

Kari Marie Martinsen, a Norwegian nurse and philosopher, states care is a relationship of senses and bodies that should be concrete and present (Martinsen, 1991). She states care should always "be a movement away from ourselves and towards the other" (Martinsen, 1991). Martinsen states that care "forms not only the value base of nursing but is a fundamental precondition for our lives" (Martinsen, 1991). Martinsen's theory, philosophy of caring, states that as nurses, he/she should learn how the patient will be best helped (Martinson, 1991). Her theory teaches that there is a need to see the patient as a living breathing being rather than a task that needs to be completed (Martinsen, 2003). Another nursing theorist, Jean Watson, teaches through her philosophy and science of caring that caring is vital to a nurses' practice (Watson, 2008). Watson states "effective caring promotes healing, health, individual/family growth and a sense of wholeness, forgiveness, evolved consciousness, and inner peace that transcends the crisis and fear of disease, diagnosis, illness, traumas, life changes, and so on." (Watson, 2008). Watson's theory of caring explains how a person should be accepted as a person in their current state and the state, they will become (Watson, 2008). Having a caring relationship invites the development of the human spirit (Watson, 2008). Having human-to-human connections keeps the sense of humanity alive (Watson, 2008). According to an article about patients' experiences with nurses, McCabe discusses how patients reported they felt nurses were too busy with tasks rather than communicating with them (McCabe, 2004). One patient reported that it cheered him up when the nurse simply asked how he was doing (McCabe, 2004). Patients reported non-verbal

communication was a gauge of the nurses' genuineness because it expressed "emotional support, understanding, and respect for them as individuals" (McCabe, 2004). Figure 1.

Figure 1

Theoretical/Conceptual Framework



Hypothesis

Electronic medical records may have given access to multiple disciplinary team members at the click of a button, but it also has negative consequences. Patients not only crave attention to be expressed to them in a caring way, but they deserve the respect of being cared for by a nurse and not seen as a task to be completed. The goal of this project was to help nurses not only see the importance of caring but help them incorporate it into their practice. Caring is the lost art of nursing in the world of EMR's.

CHAPTER II

Literature Review

Electronic medical records (EMR) were mandated for healthcare institutions to utilize to help streamline the patient's medical information. A nurse at the bedside of a patient can enter the blood pressure of a patient and within seconds the patients' provider can view it. Potential problems may emerge unless the nurse engages with the patient, the nurse may never understand why the blood pressure is so high despite the medication intervention that was administered. With the following literature review, it was shown that patients desire a therapeutic and trusting relationship with the nurse and to be treated as a person and not an object (Strauss, 2013). A nurse being at the bedside of a patient for such a short time and staring at a computer much of that time hinders the ability for this to be a reality (Glantz et al., 2019). However, by researching Scopus, National Center for Biotechnology Information (NCBI), PubMed Central (PMC), Cumulative Index for Nursing and Allied Health Literature (CINAHL), and ProQuest, strategies to assist the nurse with building a positive relationship with the patient were found. These can be valuable strategies for healthcare institutions to implement since the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) uses patient satisfaction scores to assist with reimbursement for services rendered (Centers for Medicare & Medicaid Services (CMS), 2021).

Literature Related to the Purpose

Communication consists of non-verbal and verbal skills. How the patient perceives this interaction, along with the lack of awareness by the nurse can ultimately negatively affect this relationship (McCabe, 2004). A study by Catherine McCabe was

conducted to “explore and produce statements relating to patients’ experiences of how nurses communicate with them” (2004). Unstructured interviews were performed with eight purposeful patients from a teaching hospital. The four main themes that emerged were lack of communication, attending, empathy, and friendly nurses with humor with the lack of communication identified as the largest finding (McCabe, 2004). Many participants stated how nurses did not provide enough information and gave the impression that they, the nurse, were more concerned with the task than with talking with them, the patient (McCabe, 2004). The study participants indicated “nurses do not always communicate in a patient-centered way even when they have the ability to do so” and “the nurse-patient interaction is heavily influenced by the work and culture of the organization” (McCabe, 2004). A limitation to the study was noted as having such a small number of participants (McCabe, 2004). The findings of this study suggest that task-oriented nursing is being utilized. If management of healthcare facilities wants to ensure that patients in their care receive quality nursing care, they need to think about the impact of patient-centered communication and make this a priority in their facilities (McCabe, 2004).

In a systematic review of empirical literature on patient-physician communication, it was the goal to “better understand how EMR’s maybe transforming patient care through their impact on communication” (Rathhert et al., 2015). This study defined communication as information that is exchanged verbally, physically nonverbally, and electronically. The search engines used were MEDLINE/PubMed, CINAHL, and PsycINFO with all published article information on or before August 11, 2015. There were 41 articles that met the criteria and used out of the 2,173 articles that

were initially found. The information was categorized into six communication functions: fostering healing relationships, exchanging information, responding to emotions, managing uncertainty, making decisions, and enabling self-management (Rathhert et al., 2015). There was a lot of evidence that the EMR has the potential to undermine the development and the maintenance of healing relationships if too much attention is spent gazing at the computer and on keyboarding (Rathhert et al., 2015). Rathhert et al. (2015) gave credit to EMR's in the way they can capture, share, and analyze patient information and two, to facilitate diagnosis, decision making, and treatment plans, but at a cost to the healthcare provider and the patients relationship. The combination of time restraints and focusing on the computer can cause the healthcare provider to miss subtle cues that can be crucial for developing trust, rapport, and optimal treatment plans (Rathhert et al., 2015). Despite the limitations of being dependent on the studies retrieved for their accuracy, small sample sizes of the studies being reviewed, and interventions, and that some of the studies had communication measures that were poorly described; this systematic literature review charges how it is vital to better understand how EMR use affects the healthcare provider and patient relationship because the technology is here to stay (Rathhert et al., 2015).

Qualitative research was performed to investigate the patient's perception of the nurse-patient relationship when the Electronic Medical Record (EMR) is utilized at the patient bedside (Strauss, 2013). Eleven patients with a chronic nonthreatening illness who had a 3-5-day hospital stay were recruited for this study (Strauss, 2013). The qualitative survey question was "What is the experience of hospitalized patients when nurses communicate with them whole using an electronic health record?" (Strauss, 2013). After

compiling, assessing, and evaluating the open-ended interview questions, the qualitative data analysis computer software titled NVivo 9 analyzed four themes: presence, respect, knowledge, and safety and trust (Strauss, 2013). One of the participants expressed disappointment when the nurse entered the room and went straight to the computer without recognizing or speaking to the patient first. Some of the participants spoke about the lack of being treated as a human being. They reported having feelings of being treated like objects. The participants acknowledged the nurse needed to utilize the EMR but felt it could distract the nurse from "being there". Limitations of the study include that there was a small group of mostly Caucasian race of whom all were high school or college graduates as the participates of this study. Four implications for nursing practice and education resulted from the findings:

> (1) acknowledge and attend to any healthcare needs as soon as you enter the patient's room prior to using the electronic health record; (2) explain all movements on the computer including when personal health care data are entered; (3) explain the rationale for electronically generated questions and nursing protocols; and (4) acknowledge and attend to any healthcare needs before leaving a patient's room. (Strauss, 2013)

Strauss charges that nurses do not forget about the human connection aspect with the continuing growth with EMR's (2013).

In a study of 295 patients in a burn unit in Iran, it was shown there was a significant dissatisfaction from nursing services (Lotfi et al., 2019). This descriptive-correlational study was performed to investigate the professional communication between patients and nurses and the patients' satisfaction with nursing services. The study had

100% participation of the 295 patients that were being discharged over 3 months in fall of 2018. All questions for the study were asked in the patients' room, 20-30 minutes before the patient was discharged from the hospital. Fifty percent of the patients had been in the hospital more than 9 days. Patients' reported "fails to consider my opinions and preferences regarding plans for my care," "should be more thorough," "neglects to be sure I understand the importance of my treatments" and "makes me feel like a case, not an individual,". More than 80% reported they did not know their nurse. Due to the low sample size and being conducted in the burn unit, the results cannot be generalized to other areas or diseases. The study suggests that "use of appropriate communication skills may increase patients' level of satisfaction towards nursing care (Lotfi et al., 2019).

Glantz et al. (2019) logged almost 130 hours observing 12 registered nurses over six inpatient psychiatric units between the hours of 7:00 am and 9:00 pm. Descriptive statistics were used to analyze the task frequency, time, and number of interruptions that were recorded. Before the actual study was conducted, 20 hours were spent in a preparatory pilot observation. The purpose of this observation was to train and ensure the observers were consistent with the data collected and to identify and define the tasks. There were 968 individual activities that were recorded and part of 11 predetermined task categories. It was found that 17.5%, the largest amount of the nurse's time, was spent performing medication tasks. The third-largest time, 15.3%, spent by the nurse was with direct patient care. This included time spent with the patient, planning care in collaboration with the patient, or drawing blood. It was discovered that 8 minutes was the amount of time spent performing a direct care task. Due to such a small amount of time

being spent at the bedside of the patient, it created a doubt on whether a therapeutic and trusting relationship between the nurse and the patient could be established.

Chan et al. (2013) explored registered nurses' opinions with time concerns in the workplace. Healthcare costs and efficiency are associated with time and therefore there is an increased focus on task-oriented clock time (Chan et al., 2013). The questions asked for this qualitative study were, "How do nurses describe their time spent caring for patients in their particular settings?" and "How does their understanding of time affect them and their work?" (Chan et al., 2013). Five registered nurses were interviewed, three times each, over a 1-year time frame (Chan et al., 2013). Although the sample size was small and the nurses from only two locations, it allowed the authors of the study to generate 30 hours of in-depth data (Chan et al., 2013). Three themes emerged:

> "time and nursing work: lack of time gets in the way of getting to know patients and families", "the priorities of nurses and nursing", and "working collegiality and opportunistic communication with patients." (Chan et al., 2013)

Among the three themes that emerged, one thing was prevalent, time pressures encouraged cooperation among colleagues, but it has negative consequences for patient care (Chan et al., 2013). Nurses reported seeing their work as tasks to be completed and anything more as "extra work" (Chan et al., 2013). One nurse stated how a patient became a "person" when she had a conversation with the patient's husband (Chan et al., 2013). She stated she felt guilty for seeing the patient as a "time-consuming" object (Chan et al., 2013). It was shown that routines are a method of working in response to a surplus of demands on the time available (Chan et al., 2013). The takeaway from this study, managers, and policymakers should note that nurse's routinization in the challenge

of time leads to detrimental levels of patient care and nurses have a sense of guilt (Chan et al., 2013).

Hendrich et al. (2008) wanted to explore the amount of time nurses spend on the following activities: nursing practice, unit-related functions, nonclinical activities, and waste. They had 767 licensed nurses volunteer to participate from medical-surgical units of 36 different hospitals. Hospitals have to deal with increasing challenges due to growing technologies and reimbursement policies, demographic trends, competing fiscal demands, and a deteriorating workforce shortage (Hendrich et al., 2008). A restructure of the hospital design and work process can hold the potential to affect the "efficiency and effectiveness of care delivery for the foreseeable future" (Hendrich et al., 2008). For the study, the nurses' time was divided into categories and the location of the activity. The results were: documentation accounted for 35.3% (147.5 minutes), care coordination 20.6% (86 minutes), patient care activities 19.3% (81 minutes), medication administration 17.2% (72 minutes), and only 7.2% (31 minutes) was used for full patient assessment (Hendrich et al., 2008). These authors of this study suggest that changes in technology, work processes, and unit organization and design could potentially improve the use of the nurses' time and the safe delivery of care (Hendrich et al., 2008).

In a longitudinal analysis of 326 medical-surgical units of acute care hospitals in California, the hypothesis that EMR's are associated with lower hospital costs and length of stay was found to be false (Furukawa et al., 2010). Data on nurse staffing was collected from 1998-2007. It was shown that after EMR's were implemented, there was a 6-10% higher cost per discharge in the medical-surgical units (Furukawa et al., 2010). From the data collected, it also showed there was a decreased rate of mortality for

conditions but however an increased rate of complications (Furukawa et al., 2010). Surveys with the nurses revealed the attitude that EMR's may improve the quality of documentation but results in an increase in computer-related tasks. The study revealed that nurses may create workarounds due to incompatible systems, poor implementation, and lack of integration with EMR's and in turn, this creates errors and inefficiencies. The study found that EMR use increased staffing needs and decreased patient safety. Limitations associated with this finding included the inability to see quality improvement initiatives. The findings of this study "provide empirical evidence on the impact on EMR in community hospitals" (Furukawa et al., 2010). Due to the results, there is an implication that EMR's may increase the demand for skilled nurses (Furukawa et al., 2010).

The purpose of a qualitative study by Kossman and Scheidenhelm was to look at how community hospital nurses view the impact of EMR use on not only their work but on patient outcomes as they provide patient care (2008). Medical-surgical and intensive care units at two community hospitals within a regional Midwestern health care system were involved in this study. Of the 46 nurses who volunteered there was no race, gender, or age restriction. Forty-one nurses were from the larger urban hospital located in a mid-size city that has 157 beds. The remaining 15 nurses were from a 47 bed smaller rural hospital. The questions that were being addressed in this study included: "How do community hospital nurses use [EMRs]? What effect do they think [EMR] use has on their ability to perform nursing care? and What effect does [EMR] use have on patient outcomes? (Kossman & Scheidenhelm, 2008). The negative findings included the nurses reporting that EMRs hinder critical thinking skills; time was significantly decreased with

the patient, because of the time it took to retrieve or document information; and the time spent at the bedside lacked personalization which could affect patient safety and patient outcomes. Due to the self-reporting of information from the nurse participants, usage of time could have been overestimated. Implications of this study included updating EMR systems that will improve time efficiency, that will better support critical thinking, and improving ways that enhance bedside use (Kossman & Scheidenhelm, 2008).

Literature Related to the Theoretical/Conceptual Framework

The Institute of Medicine (IOM) created six objectives for improving healthcare in the 21st century. One of those objectives is patient-centered care. Quality patient care has been defined as "providing care that the patient needs in the manner the patient desires at the time the patient desires" (Rathert et al., 2015). In a study involving patients who had a 24-hour or more stay at one of 142 acute care hospitals across the U.S., it sought to answer the following questions: "Are the theoretical dimensions of patient-centered care predictive of overall quality of care ratings?" and "Is each theoretical dimension equally predictive of overall quality of care ratings?" (Rathert et al., 2015). Seven dimensions were measured: respect for patient preferences, values and expressed needs; coordination of care; information, education, and communication; physical comfort; emotional support, involvement of family and friends; and continuity and transition. Of these seven, the one that had the strongest relation to overall ratings of care was emotional support. It can be distressing for patients to have to stay overnight in the hospital, if nurses will do what they can to relieve that distress, then patient perceptions of their overall care can be influenced in a positive way. The second strongest relationship with overall care ratings was the coordination of care. It was shown that

patients related coordination of care with patient safety issues (Rathert et al., 2015). The third strongest predictor of overall satisfaction was physical comfort. Patients indicated that if staff appeared to be doing everything they can for the patient's comfort, then patients indicated they had a better overall experience (Rathert et al., 2015). The study proposes that understanding the patient's viewpoint of patient-centered care will help advance research and practice. Specific outcomes of care can be better predicted, and measures can be improved (Rathert et al., 2015). This can improve nursing practice and therefore leaders can justify changes for improvement (Rathert et al., 2015).

In an article written by Peck (2013), she addresses the fact that EMR's do not need to be a barrier to good communication between a healthcare provider and a patient. The Academy of Family Physicians (AAFP) states it is important to recognize the computer as the "third party in the room" when entering the patient's room (Peck, 2013). The nurse needs to bring the patient into the interaction he/she is having with the computer (Peck, 2013). The nurse should allow the patient to see the computer screen once the patient's chart is visible. This allows the patient to see what the nurse is doing during the nurse-patient interaction. The article suggests basic skills when using the computer, such as learning to type and mastering basic computer skills, but there are some things the nurse needs to also consider and practice. The nurse needs to learn how to listen to a patient's concern before opening the computer screen, tell the patient what he/she is doing at the computer when entering information, the nurse should point to the screen when sharing information from the computer, understand when it is needed to push the computer away and encourage the patient to participate in building their chart

(Peck, 2013). LEVEL up is a great acronym that is referenced in the article and is as follows:

- L-Let the patient look on: have the computer screen positioned so the patient can see it, invite, and ask the patient to verify the information as entered.
- E-Eye contact: use eye contact when greeting the patient.
- V-Value the computer as a tool: tell the patient how the computer improves care.
- E- Explain what you were doing: involve the patient in what is being done on the computer, such as looking up medication actions.
- L-log off and say that you were doing so: let the patient know that logging off the computer is a safeguard to his or her information.

"The issue with EMR ergonomics is not to make the EMR tolerable", but "to make the encounter better than it would have been without the EMR" (Peck, 2013).

Rose et al. (2013) interviewed 21 out of the invited 1,000 adult patients within a diabetic clinic in Baltimore Maryland. The participates were 18 years and older before and after the implication of EMRs. The providers in this clinic had been using the EMR for approximately 2 years before this study was initiated. Most of the patients were African American, socioeconomic status ranged from homeless to wealthy, and all patients were established with the practice. The interviews were audio-recorded with handwritten notes taken at the time. Four themes emerged from the study: communication issues, patient preferences for EMRs, safety and security concerns, and transition problems. This study validated the importance of the need for providers to have an active conversation during the visit and involve the patient in the documentation by showing the test results recorded in the EMR. Patients reported that positioning the EMR

on a desk with the patient and practitioner viewing the information on the computer together was welcoming. The study noted that "patients perceived eye contact as an indication that providers cared about them" (Rose et al., 2013). Patients reported how they felt ignored when backs were turned to the patient as the provider typed in the computer (Rose et al., 2013). Limitations for this qualitative phenomenological study included being limited to 21 patient interviews at a specific type of outpatient clinic. It also noted that responses of the patients were based on individual pinions that could have been negative toward computers and/or EMR's (Rose et al., 2013). Acknowledging the patient throughout the interaction and explaining what is being entered or reviewed on the EMR can help promote a positive outcome with the nurse-patient relationship.

A systematic literature review of 148 published articles between January 2007 and March 2017 was performed "to investigate the changing role of health care professionals in nursing homes and to investigate the conditions that make this change possible" (van Stenis et al., 2017). These goals were addressed by examining the current changes in the roles of nursing homes, the needs of the caregiver related to the changes, and the skills and competencies necessary for those changes (van Stenis et al., 2017). After using the Mixed Methods Appraisal Tool (MATT) at various levels for a quality assessment, 24 studies remained. Although it is assumed that developing a relationship through daily care comes naturally, it is actually controlled by the caregiver. The types of relationships that can be established are individualized and task-oriented, patient-centered, and relationship-centered. Although patients have more positive outcomes with the patient-centered and relationship-centered interactions, these are not being actively practiced. It was discovered that if the caregiver would be able to effectively provide care

to the patient if the patients' needs emotions were understood. A list of skills and competencies were compiled and considered necessary for caregivers to build positive patient-centered and/or relationship-centered interactions.

- Communication: Listening skills, providing feedback, discussing choices, discussing complaints, and building relationships in daily care
- Attentiveness: Being open to clients' worries, picking up signals, and addressing emotions
- Negotiation: Taking into account the interests of those involved, facilitating conversations between those involved, making decisions after consideration, and solving conflicts
- Flexibility: Observe and adjust to the needs of clients, and creative problem-solving
- Teamwork: Working with colleagues from diverse backgrounds, taking responsibility as a team member, daring to ask questions, supporting colleagues, complementing other colleagues' qualities
- Expertise: Specific knowledge regarding health, palliative care, dementia, ethics, IT, use of medicine, etc
- Coaching and leadership: Coaching colleagues, taking the initiative to exercise influence (van Stenis et al., 2017)

Even though this literature review was limited to nursing homes, based on "self-reports" from participates rather than "objective" data, and a relatively small number of articles, the relationship-building information can be utilized across various healthcare institutions to promote positive patient outcomes.

CHAPTER III

Needs Assessment

Healthcare institution reimbursement for services rendered is influenced by patient satisfaction scores from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (CMS, 2021). When the use of the electronic medical record (EMR) was mandated, the nursing focus changed from the art of nursing to task-driven nursing. Data collected from patients regarding the use of EMRs are affecting the patient satisfaction scores in a negative way (Heath, 2007). It would be of great benefit for a healthcare institution to learn and implement the strategies presented in this project to assist the nursing staff to return to the art of nursing. Therefore, patients at a healthcare institution would report data that would reflect positive patient satisfaction leading to higher HCAHPS scores and monetary reimbursement**.**

Target Population

The target population for this project consists of approximately 1,600 full-time, part-time, and per diem nurses, 500 full-time, part-time, and per diem nursing assistants, and 75 administrative staff members employed at an acute care hospital setting. The gender of the population consists of 75% female and 25% male. There is a predominantly Caucasian race at 74%, African-American race at 20%, Hispanic race of 3%, and 3% listed as other.

Target Setting

The project setting was an acute care setting in Western North Carolina (WNC) whose mission is to improve the health of those living in WNC and the surrounding areas. By utilizing this project, they will foster their value of teamwork to create a caring

and compassionate environment, meet and exceed the needs of their patients and consumers while respecting the person as an individual. The aim of this project aligns with the institution's aim of being driven to ensure each person, family, and team member has an exceptional experience.

Stakeholders

This project will be presented to the administrative staff which includes the Chief Executive Officer (CEO), hospital board members, the Chief Nursing Officer (CNO), Human Resources team members, and members from the nurse educator's department. After approval of project implementation is received, detailed material will be presented to the nurse educators of the various departments within the hospital. The departments included are all medical-surgical units (med-surg), Intensive care units (ICU), Cardiovascular units, Neurology units, Oncology unit, Labor and Delivery (L&D), Mother and Baby, Neonatal Intensive care unit (NICU), pediatric units, and the Emergency Department (ED).

SWOT Analysis

A strategy for identifying the strengths, weaknesses, opportunities, and threats (SWOT Analysis) of this project is provided in Figure 2. The informational presentations and training classes included the literature reviews pertaining to EMR's with patient-centered communication and nurse-patient relationships. Strengths include a strong literature review to support the information being presented and the program is financially feasible once set up for long-term use. The weaknesses include potential concerns with time needed for the classes with the staff nurses and nursing assistants and the turnover rates with the staff nurses and nursing assistants necessitating the need to

hold extra classes. Improvements in the nurse-patient relationships and improvements with the nurse-patient communication are opportunities. There is also the opportunity to increase monetary insurance reimbursement due to patient satisfaction scores and opportunity to improve nurse work environment satisfaction and therefore decrease nursing staff turnover. Threats include nursing staff resistance to change, time needed for training, classes being held on different shifts, and participation in the entire program.

Figure 2

SWOT Analysis of Project Implementation

STRENGTHS	WEAKNESSES
• Literature review to support the information being presented • Financially feasible once set up for long term use	• Potential for concerns with time needed for the staff nurses training classes • Turnover rates and the need to hold extra classes
OPPORTUNITIES	**THREATS**
• Opportunity to improve nurse-patient relationships • Opportunity to improve nurse-patient communication • Opportunity to increase monetary insurance reimbursement due to patient satisfaction scores • Opportunity to improve nurse work environment satisfaction and therefore decrease nursing staff turnover	• Nursing staff resistance to change • Time needed for training • Classes being held on different shifts • Participation in the entire program

Resources

The project leader will provide each nurse educator a three-ring binder containing the class material. Two additional copies will be given to the nurse education administrative assistants. The project leader will provide the PowerPoint presentation, student handouts, and class informational fliers to each nurse educator. Each educator will then be responsible to print the needed material for their individual classes. Classroom space was provided per policy and procedures and scheduled where and when applicable. Classrooms are equipped with tables and chairs, electronic screens, and docking stations for the employee's laptops. The initial training was provided by the project leader free of charge to the facility. Those in the initial training to be paid at either their salary or an hourly rate by the facility. The facility will also be responsible for staff training costs that will be incurred during the actual time spent training on the units at either the salary or hourly rate of the employee.

Desired and Expected Outcomes

This project offers a program to the nursing staff of an acute care hospital to educate about the importance of nurse-patient relationships and nurse-patient communication. It will educate the nursing staff with information about the negative and positive effects of communication. The project also educates about how communication can affect the nurse-patient relationship in both a negative and a positive manner. The nursing staff will be equipped with various ways to communicate verbally and nonverbally in a manner to promote a positive relationship with patients. These outcomes and the program success will be measured by the HCAHPS survey scores and in turn, the

monetary reimbursement from insurance companies for services rendered will show an increase.

Team Members

The project team consisted of the project leader, seven nurse educators from each department/unit within the acute care hospital, 14 unit preceptors, the staff development coordinator, and two education department administrative assistants. The seven nurse educators gave insight and direction on the program needs for the classes to be held on the units. The staff development coordinator gave insight and direction for the program needs for the new hire orientation class. The administrative staff assisted with acquiring and organizing the supplies needed for each class as well as assisting with the maintenance of all current employees and new hire's attendance records.

Cost/Benefit Analysis

The cost analysis in Figure 3 lists the budget for the project. The planning for the initiation of this project had no monetary cost. The training cost incurred is from the initial training of salaried and hourly employees, then the time spent training hourly employees on the units during in-service hours. There was no travel cost due to a shuttle bus system on campus. The project leader provided refreshments for the presentation with the administrative staff. The facility provided lunch for the education department training and refreshments for the classes being held on the units. The facility incurred the office expenses for the bound copies of the program, printed copies of the PowerPoint presentation, the printed fliers, and the posters.

Figure 3

Budget

Project Planning and Implementation	Budget
Planning	$0.00
Training (salary costs)	$50,000
Travel	$0.00
Program introduction refreshments for administrative staff	$150
Lunch for education department training	$250
Refreshments for the classes being held on the units	$500
Bound copies of the program	$200
Printed copies of the PowerPoint presentation for the nurse educators and staff development coordinator	$50
Printed fliers	$300
Posters	$150
Total	**$51,600.00**

Conclusion

HCAHPS scores help determine the monetary reimbursement healthcare institutions receive. Utilizing the EMR as an effective educational tool to engage patients in the nurse-patient relationship rather than the EMR being utilized as a task to be completed can be beneficial (Zhang et al., 2016). By implementing this project, it can prove to be valuable for the acute care institution to get back to the art of nursing.

CHAPTER IV

Project Design

Electronic medical records were mandated to streamline care for all the disciplines, but it has created some negative consequences. Patients are reporting they feel as if the nurse needs to get tasks completed rather than expressing care and compassion towards them. This chapter will share the plan of how to equip nursing staff to improve the nurse-patient communication and therefore improve the nurse-patient relationship.

Goal

This project has shown there is a patient-perceived lack of bedside nursing care while performing tasks with the use of the EMR. Nursing staff should utilize bedside nursing strategies to show a caring attitude to the patient while performing tasks guided by the EMR. The goal of this project was to remove the barriers to effective communication while nursing tasks continue to focus on the utilization of the EMR.

Objectives

The objectives for this project were as follows:

- Present comprehensive professional knowledge and evidence-based strategies that will engage bedside nursing staff and patients into a positive and productive nurse-patient relationship.
- Illustrate effective leadership that guides the nurse educators, unit preceptors, and the staff development coordinator.
- The nursing staff will be able to confidently participate in positive and effective nurse-patient communication.

- The nurse-patient relationship will show improvement as evidenced by an improvement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores 3 months after the initiation of the program with the bedside nursing staff.
- Analyze how the nurse educators, unit preceptors, and the staff development coordinator can develop a plan for ongoing education to sustain the Art of Nursing program.

Plan and Material Development

An introductory session for this project includes a PowerPoint (PPT) presentation (Appendix A) with the administrative staff which will include the Chief Executive Officer (CEO), hospital board members, the Chief Nursing Officer (CNO), Human Resources team members, and members from the nurse educator's department. The purpose of this session will be to provide information about the importance of the nurse-patient relationships and nurse-patient communication and gain approval to proceed with the 'Art of Caring' program.

A training session will then be held with the entire nurse educator department. The nurse educators, unit preceptors, and the staff development coordinator were given the PPT presentation in electronic and written form (Appendix A), including timelines (Figure 4), Art of Nursing Program (Appendix B), leader-guided class participation practice sessions (Appendix C), guided student-lead role-playing (Appendix D), and the evaluation forms to present and evaluate the program with the staff nurses and nursing assistants on the identified units.

Once the 8-hour training session was completed with the nurse educators, unit preceptors, and the staff development coordinator, those nurse educators will implement the training process with the nursing staff on the various units in the three classes as listed in the timeline.

- The initial 60-minute class will consist of the staff nurses and the nursing assistants being introduced to the project via the PPT presentation (Appendix A).
- The second class, approximately 3 hours long, will consist of teaching the strategies and rationale for the Art of Nursing Program (Appendix B). There will also be time built in for the leader-guided class participation practice sessions (Appendix C) and the guided student-lead role-playing (Appendix D).
- The third class will be a review of the project with an evaluation including a written and verbal feedback session from the staff nurses and nursing assistants after implementing the strategies that were taught in the second class.

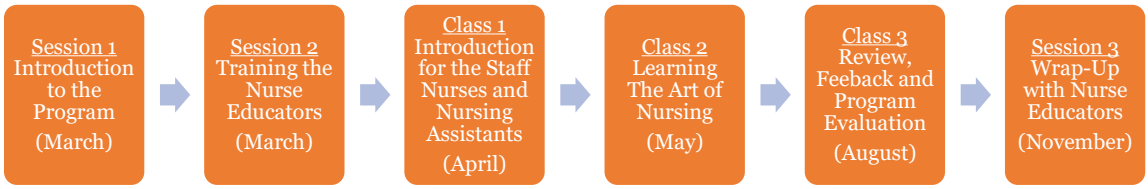
Session 3 will be a wrap-up session with the project leader, the nurse educators, unit preceptors, and the staff development coordinator. The written evaluations from the nursing staff will be reviewed and discussed, as well as the data collected on the units by the unit managers and the comparable data from the HCAHPS survey will be presented and discussed. This session will also give the team time to discuss the future of maintaining this program.

Timeline

As illustrated in the timeline (Figure 4), the program will start with session 1 to introduce the program to the administration staff, etc., session 2 will train the nurse educators, followed by three classes to train the staff nurses and nursing assistants, and then ending with session 3 to wrap-up with the nurse educators and discuss the future of maintaining the program. Each session is to be offered and led one time each by the project coordinator. Each of the three classes will be offered and taught three times each by the unit nurse educators throughout the month to accommodate the bedside nursing staff schedules.

Figure 4

Project Timeline



Budget

The following expenses are estimated for the acute care facility. The planning for the initiation of this project has no monetary cost. The training cost incurred is from the initial training of salaried and hourly employees, then the time spent training hourly employees on the units during in-service hours is estimated at $50,000. There was no travel cost due to a shuttle bus system on campus. The project leader provided refreshments for the presentation with the administrative staff, budgeted at $150. The facility provided lunch for the education department training estimated at $250.

Refreshments for the classes being held on the units are budgeted at $500. The facility incurred the office expenses for the bound copies of the program, which is expected to be $200, printed copies of the PowerPoint presentation $50, the printed fliers $300, and the posters estimated at $150. The total budget for this project is $51,600 (Figure 3).

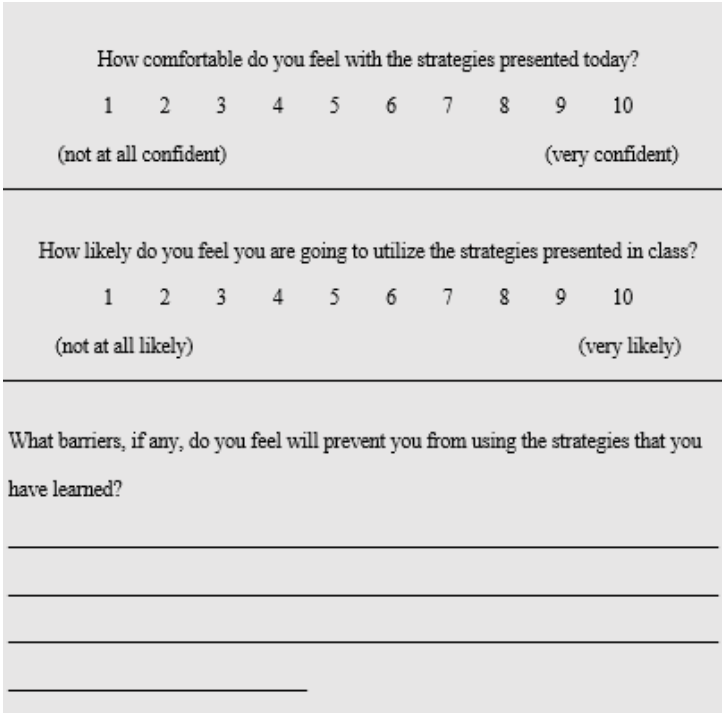
Once the program has been introduced and implemented, the program content will be maintained through the annual competency program that is completed with online modules. The actual content in the module will not have a monetary cost. The staff member's time it will take to create the online module is included with the training estimated cost of $50,000 for initial training.

Evaluation Plan

The nursing staffs' confidence with utilizing the Art of Nursing strategies will be evaluated by the self-assessment surveys. Figure 5 will be given to the participates at the end of class two. Figure 6 will be given to the participates at the end of class three. The data will then be collected, analyzed, and discussed among the nurse educators.

Figure 5

Nurse and Nurse Aide Self-Evaluation (Pre-Implementation)



How comfortable do you feel with the strategies presented today?

1 2 3 4 5 6 7 8 9 10

(not at all confident) (very confident)

How likely do you feel you are going to utilize the strategies presented in class?

1 2 3 4 5 6 7 8 9 10

(not at all likely) (very likely)

What barriers, if any, do you feel will prevent you from using the strategies that you have learned?

_____

_____

_____

_____

Figure 6

Nurse and Nurse Aide Self-Evaluation (Post-Implementation)

How often do you feel you used the Art of Nursing strategies?

1 2 3 4 5 6 7 8 9 10

(not at all) (every patient interaction)

Do you feel it made a difference with the patient 's perception of care? Give an example of why or why not.

_____

_____

_____

_____

_____

What do you think should be added to the program to improve content, instruction time, practice time, etc.?

_____

_____

_____

Comments:

_____

_____

_____

_____

The daily evaluation of the program will be evaluated from the data collected from the mandatory leadership rounds with patients on the unit. Questions to be added and asked the patient include:

- Do you feel as if your nurse and nursing assistant have tried to get to know you or do you feel as if he/she has been in a hurry to get things completed to be able to leave the room?
- Has your nurse and nursing assistant been making eye contact with you and are they calling you by name?
- Do you feel as if the nurse and the nursing assistant were attentive to your needs in a compassionate and caring way?

Patients are given the opportunity to fill out surveys at discharge and asked if they would like to nominate a nurse for the Daisy award and/or a nursing assistant for the Compassion in Action Award. The weekly success of the program will be evaluated based on the survey results and with the increase of these two awards. The monthly success of the program will be evaluated from the improvement of the HCAHPS survey scores.

Conclusion

The use of EMR's was mandated by the PPACA and has had a negative effect on the nurse-patient relationship. Nurses and nursing assistants have become more focused on the tasks to be completed and lost sight of the compassionate nursing that patients desire. By learning and implementing the strategies introduced in this project, the nursing staff will be able to get back to the 'Art of Nursing'.

CHAPTER V

Dissemination

Through the implementation of the 'Art of Nursing' classes, the nursing staff of an acute care facility in Western North Carolina (WNC) will be equipped with the knowledge needed to promote and maintain a positive and effective nurse-patient relationship. Evidence has supported the idea that patients feel as if their care is merely a list of tasks to be completed since the implantation of electronic medical records (EMRs). Patients desire and deserve effective nurse-patient communication. It is time to get back to the 'Art of Nursing'.

Limitations

This project will be limited to just one of many acute care facilities in WNC. There are only a few acute care facilities in WNC, but there are acute care facilities located across the United States (U.S.) that could benefit from the information contained in this project. There are also numerous privately owned and corporate-owned physician offices and even urgent care facilities utilizing EMRs where patients seek medical care when nurses and nursing assistants could be equipped with strategies to promote positive and effective nurse-patient communication.

Another limitation to this project was the possibility of not every nurse participating in the program. There is the possibility of nurses and/or nursing assistants being absent for personal reasons, vacations, or even unforeseen circumstances from education sessions. There is also the possibility of nurses participating but resisting the change that is being presented in the project. There is a concern about the honesty of the

nursing staff responses on the *Nurse and Nurse Aide Self-Evaluation* questionnaires. Nursing staff could feel as if they are pressured into participating in classes.

Implications

Communication between a nurse and a patient can be vital to the patient receiving accurate and effective care. The use of an electronic medical record can be a barrier to this care. It is important to equip not only the nursing staff of one acute care facility but to equip nursing staff across the United States. There are a few ways to help make this educational goal a reality. Once the program has been established and has proven its worth, the program can be presented to the corporate office. It is there where the program can be introduced and then initiated at all the facilities this corporate organization owns. Another way to educate nurses in a broader setting is to have the project published in peer-reviewed journals such as the American Journal of Nursing, Nursing in Practice, and Nursing Times. There is also the possibility to have the project presented at local, regional, state, and national conferences. Equipping nurses across all avenues of nursing can promote the 'Art of Nursing' and therefore increase the positive and effective nurse-patient relationships across the nation.

Recommendations

The result of the implantation of this project can be an important step in removing the EMR as a barrier. Once the initial implantation classes are finished and data is supporting the project at the acute care facility, a yearly education program should be maintained. Resource material should be maintained and readily available to the nursing staff by the nurse education department. There also needs to be an ongoing collection of daily, weekly, and monthly data to ensure consistent behaviors. The curriculum may need

to be adjusted based on the data collected. It would be beneficial in many ways to celebrate and reward the nursing staff for their individual improvements and for the improvements of the HCAHPS survey scores.

Conclusion

The aim of this Master's of Science in Nursing project was to not only present data to the nurse regarding the perceived lack of care while he/she is performing care tasks during the use of the EMR but to introduce the nurse to strategies that can show a caring attitude to the patient while performing these tasks during the use of the EMR. The nurse-patient relationship should have a foundation of care as defined by the Institute of Medicine (IOM, 2001). It should be this type of caring that respects and that is not only responsive to individual patient preferences, needs and values but also that ensures a patient's values guide the clinical decisions being made (Newell & Jordan, 2015). The project leader aspires to continue the program and disseminate information to help remove the barriers related to the use of the EMR and to encourage and equip fellow nurses and nursing assistants to get back to the 'Art of Nursing'.

References

Chan, E. A., Jones, A., & Wong, K. (2013). The relationships between communication, care and time are intertwined: A narrative inquiry exploring the impact of time on registered nurses' work. *Journal of Advanced Nursing, 69*(9), 2020–2029. https://doi.org/10.1111/jan.12064

Centers for Medicare & Medicaid Services (CMS). (2021). *HCAHPS: Patients' perspective of care survey*. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS

Furukawa, M. F., Raghu, T. S., & Shao, B. B. (2010). Electronic medical records, nurse staffing, and nurse-sensitive patient outcomes: Evidence from California hospitals, 1998-2007. *Health Services Research, 45*(4), 941–962. https://doi.org/10.1111/j.1475-6773.2010.01110.x

Glantz, A., Örmon, K., & Sandström, B. (2019). "How do we use the time?" - An observational study measuring the task time distribution of nurses in psychiatric care. *BMC Nursing, 18*(67). https://doi.org/10.1186/s12912-019-0386-3

Heath, S. (2007, August 2017). 3 best practices for balancing EMR use and patient engagement. www.patientengagementhit.com

Hendrich, A., Chow, M. P., Skierczynski, B. A., & Lu, Z. (2008). A 36-hospital time and motion study: How do medical-surgical nurses spend their time? *The Permanente Journal, 12*(3), 25–34. https://doi.org/10.7812/tpp/08-021

Committee on Quality of Health Care in America. (2001). Ten Simple Rules for the 21st-Century Health Care System [Table 3–1]. In *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK222277/table/ttt00001/

Kossman, S. P., & Scheidenhelm, S. L. (2008). Nurses' perceptions of the impact of electronic health records on work and patient outcomes. *CIN: Computers, Informatics, Nursing, 26*(2), 69–77. https://doi.org/10.1097/01.NCN.0000304775.40531.67

Little, K. S. (2013, January 31). *The electronic medical records (EMR) mandate.* Healthcare Law Blog. https://www.healthcarelaw-blog.com/

Lotfi, M., Zamanzadeh, V., Valizadeh, L., & Khajehgoodari, M. (2019). Assessment of nurse–patient communication and patient satisfaction from nursing care. *Nursing Open*, 6, 1189–1196. https://doi-org.ezproxy.gardner-webb.edu/10.1002/nop2.316

Martinsen, K. (1991). Care and power, words, and body in nursing. *Nursing, 2*, 2–11, 29.

Martinsen, K. (2003). Phenomenology and care. Three dialogues. *Oslo: Scandinavian University Press*. First edition, 1996.

McCabe, C. (2004). Nurse–patient communication: An exploration of patients' experiences. *Journal of Clinical Nursing, 13*(1), 41-49. https://doi.org/10.1111/j.1365-2702.2004.00817

Newell, S., & Jordan, Z. (2015). The patient experience of patient-centered communication with nurse in the hospital setting: A qualitative systematic review protocal. *JBI Database of Systematic Reviews & Implementation Reports*, 76-87. https://doi.org/10.11124/jbisrir-2015-1072

NT Contributor. (2012, January 13). *Focus on the values of nursing to boost care – not checklists*. Nursing Times. https://www.nursingtimes.net/roles/nurse-managers/focus-on-the-values-of-nursing-to-boost-care-not-checklists-13-01-2012/

Peck, A. D. (2013, September 25). Making the EHR your partner in patient care: Computers in the examining room need not be a barrier to good communication with your patients. *Medical Economics, 90*(18), 50-53. https://bi-gale-com.ezproxy.gardner-webb.edu/essentials/article/GALE%7CA349609305?u=nclivegwu&sid=summon

Rathert, C., Williams, E. S., McCaughey, D., & Ishqaidef, G. (2015). Patient perceptions of patient-centred care: Empirical test of a theoretical model. *Health Expectations, 18*(2), 199–209. https://doi.org/10.1111/hex.12020

Rose, D., Richter, L. T., & Kapustin, J. (2013). Patient experiences with electronic medical records: Lessons learned. *Journal of the American Association of Nurse Practitioners, 26*(12), 674-680. https://doi.org/10.1002/2327-6924.12170

Strauss, B. (2013). The patient perception of the nurse-patient relationship when nurses utilize an electronic health record within a hospital setting. *CIN: Computers, Informatics, Nursing*, 596-603. https://doi.org/10.1097/CIN.0000000000000014

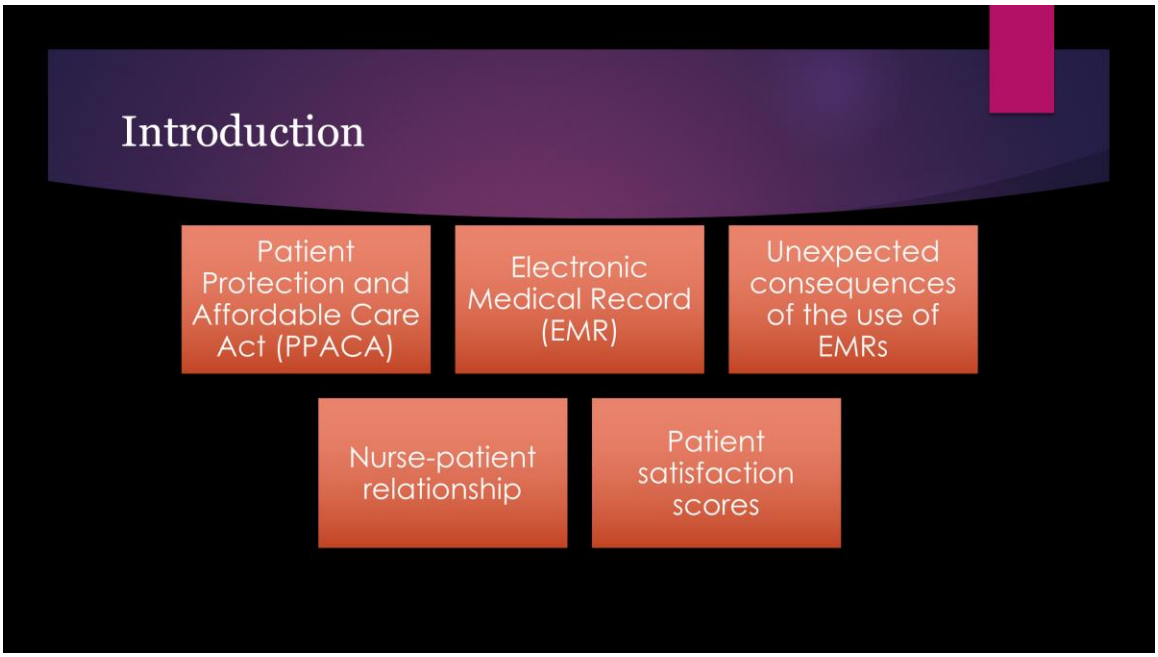
van Stenis, A. R., van Wingerden, J., & Kolkhuis T. I. (2017). The changing role of health care professionals in nursing homes: A systematic literature review of a decade of change. *Frontiers in Psychology*, 8, 2008. https://doi.org/10.3389/fpsyg.2017.02008

Watson, J. (2008). *Nursing: The Philosophy and Science of Caring: Vol. Rev. ed*. University Press of Colorado.

Zhang, J., Chen, Y., Ashfaq, S., Bell, K., Calvitti, A., Farber, N. J., Gabuzda, M. T., Gray, B., Liu, L., Rick, S., Street, R. L., Jr, Zheng, K., Zuest, D., & Agha, Z. (2016). Strategizing EHR use to achieve patient-centered care in exam rooms: A qualitative study on primary care providers. *Journal of the American Medical Informatics Association: JAMIA*, *23*(1), 137–143. https://doi.org/10.1093/jamia/ocv142

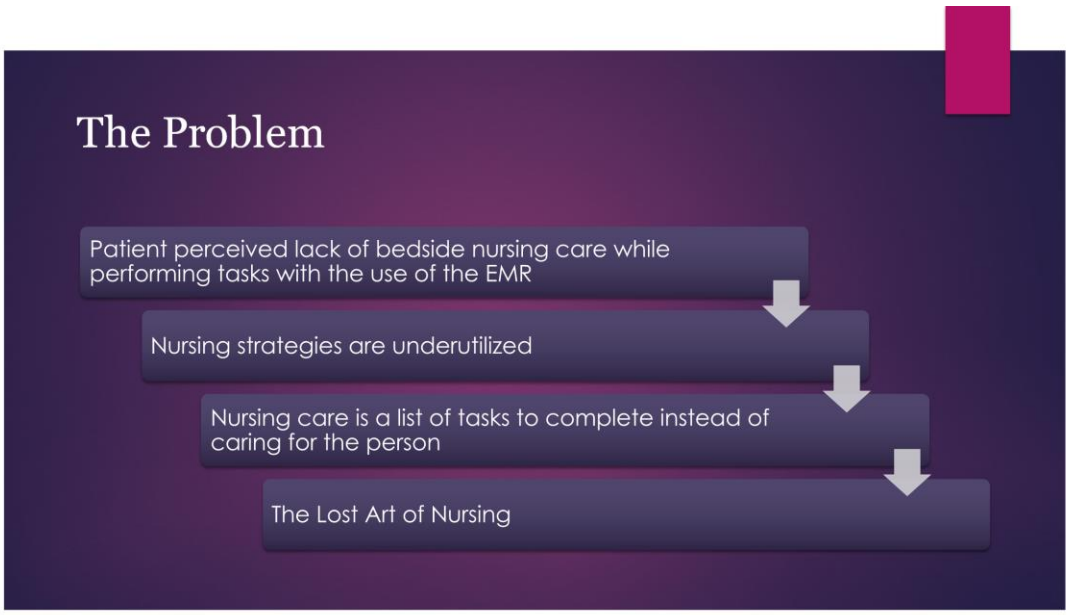
Appendix A

PowerPoint Presentation – Session 1



Slide 2 Notes: During Present Barack Obama's term, the Patient Protection and Affordable Care Act mandated the use of electronic medical records to take effect in 2014.

The purpose was to make patient healthcare information more accessible and streamlined with multiple disciplinary team members. But there were unexpected consequences. The nurse-patient relationship changed in a negative way. There is a patient perception that nurses view patient care as a task to be completed instead of seeing the patient as a person. Due to this view, patient satisfaction scores are nowhere near what they should and can be.



Slide 4 Notes: no matter age, race, gender, financial status, etc. everyone deserves respect and to be valued as a person. It is the duty of the nurse to be a patient advocate and with that duty there comes a need to coordinate care.

For a nurse to be an effective advocate, there needs to be open and honest communication between the nurse and the patient.

Communication: includes listening skills, it can help have a consistency in the workflow and create better productivity

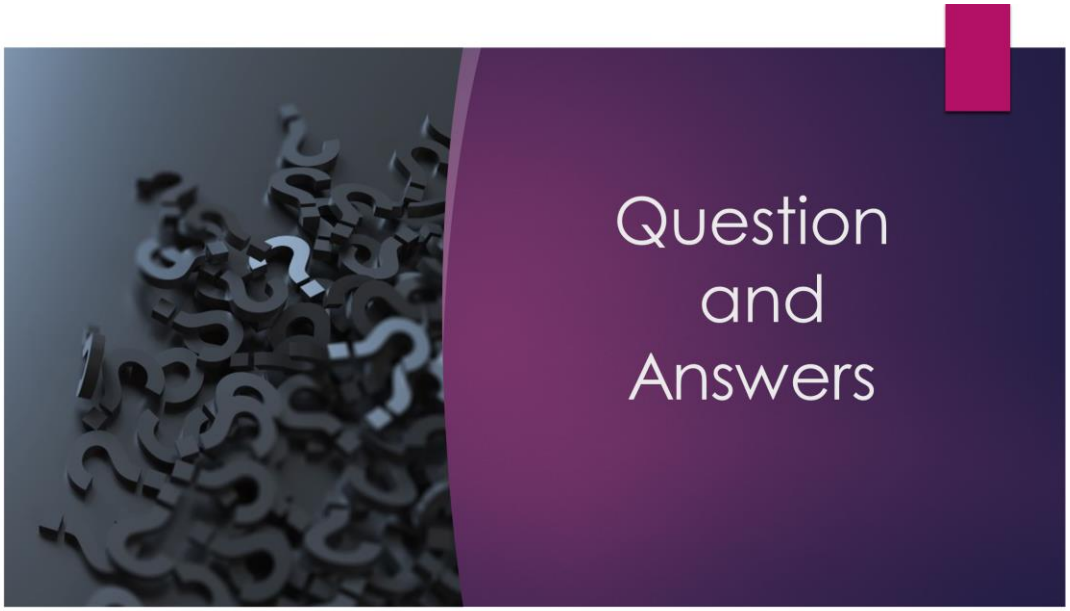
Physical comfort can improve the patient experience. It can help promote psychological wellbeing

Provide emotional support by “seeing” the patient and “hearing” them and validating the pain and/or suffering they are having

By the nursing staff supporting a patient where they are physically, emotionally, etc. will help promote a positive experience during their hospital stay, they will give a good report in the survey and therefore the hospital will gain monetary benefits.

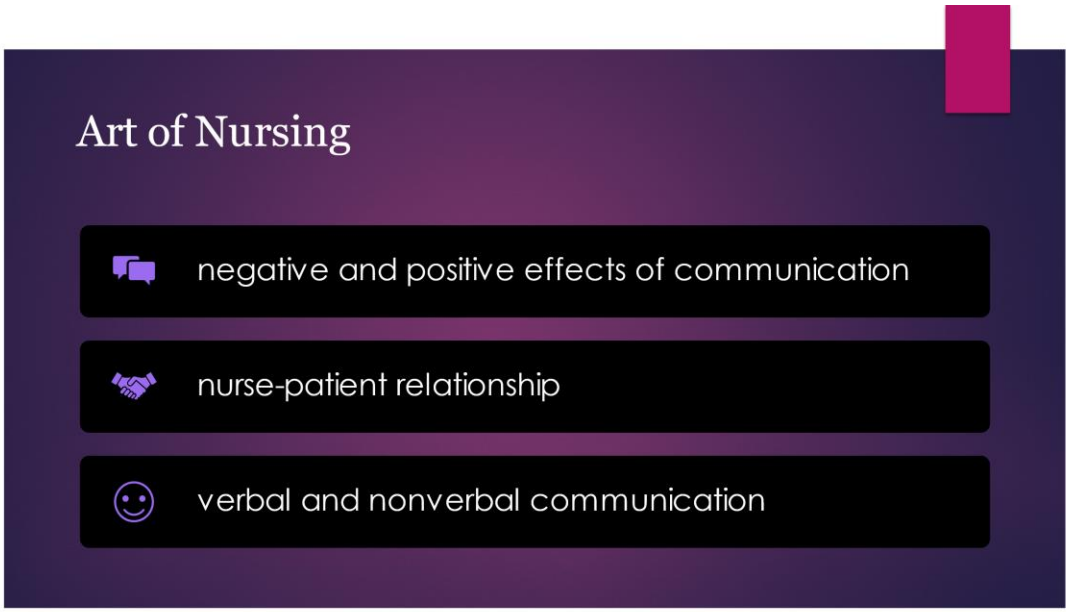
Slide 5 Notes: non-verbal communication includes facial expressions, gestures (whether intentional or not, such as looking at the clock will indicate you are in hurry, using hands to "talk" can go against culture, eye-rolling, and crinkling nose are negative gestures), body language and posture, personal space, touch, and objects & images.

verbal communication includes both spoken and written. It includes the awareness of tone of voice, loudness, expression, and pitch. It is important to understand how the words that are chosen are heard and interpreted.



Appendix B

PowerPoint Presentation – *Art of Nursing*

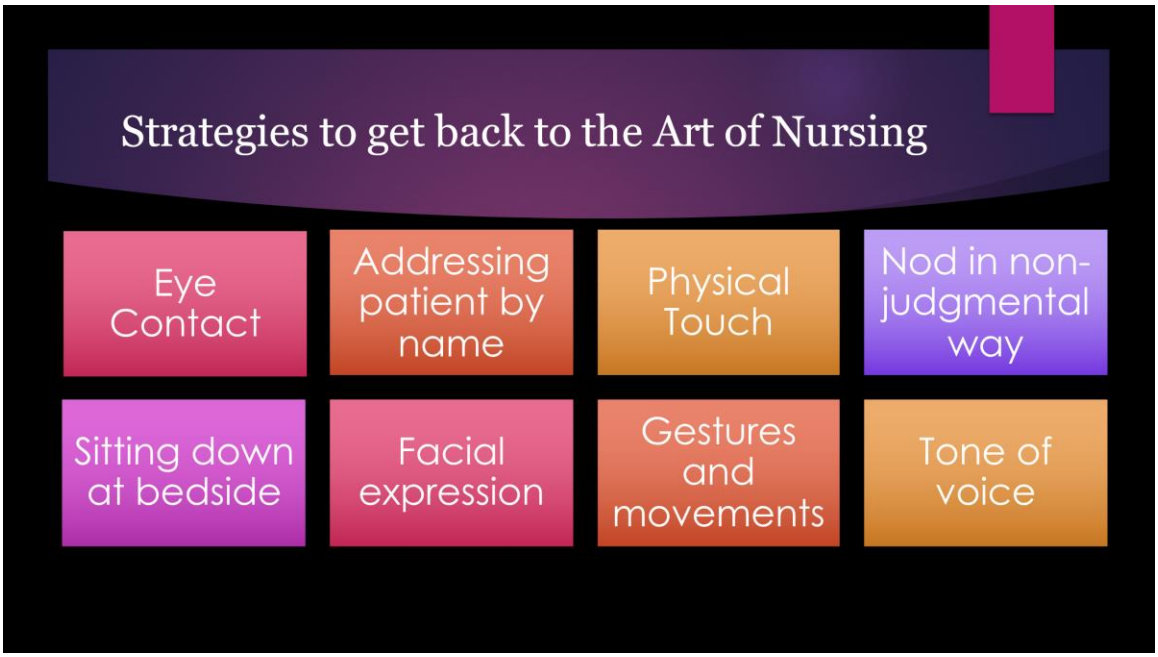


Slide 2 Notes: there are negative and positive effects of communication: if a patient is treated as a task to be completed rather than a living breathing person of whom has feelings and emotions, then that person might not share that even though the nurse administered a blood pressure medication an hour ago, the patients' blood pressure is still high and the patient has been having severe chest pain that radiates down the patients arm. Because the patient is interpreting that the nurse does not have time for them, they might never share this important information with the nurse.

The nurse-patient relationship is crucial to establish and maintain throughout the patient's stay.

Non-verbal communication includes facial expressions, gestures (whether intentional or not, such as looking at the clock will indicate you are in hurry, using hands to "talk" can go against culture, eye-rolling and crinkling nose are negative gestures), body language, and posture, personal space, touch, and objects & images.

Verbal communication includes both spoken and written. It includes the awareness of tone of voice, loudness, expression, and pitch. It is important to understand how the words that are chosen are heard and interpreted.



Slide 3 notes: as the leader: walk up to several different participates throughout the room. Do not make eye contact, introduce yourself as if walking into a patient's room: speak in a harsh and rushed tone telling them they are part of your assignment today. Stand up next to them as if to look down on them making yourself appear superior to them. With arms crossed, ask if they need anything and roll your eyes when they answer. Be short and as if bothered by the fact you are working today, tell them the unit is short-staffed today "like always" and if they need something they need to tell you now because you do not know when you will be back.

Now walk up to a few other participates and change the tone in your voice to greet participates by name while making eye contact. Touch them on the shoulder, slightly tilt your head and explain you will be available to assist them today until 7. Be open and inviting them into a conversation with your body language. Make them feel as if they are your only patient today. Offer to clean and tidy up the room, explain you are going straighten up the sheets and covers on the bed.

Ask if they feel a difference in the way they are being treated. What is different? How does each greeting feel?

Slide 4 Note: see Appendix C and D

Slide 5 Note: Use this time to review how it felt to be in the patient role for the positive and negative interactions.

Appendix C

Leader-Guided Class Participation Practice Session

Read the following scenario and have the class discuss if this is effective nurse-patient communication and the changes that need to be made.

Patient: You are in the Neuro Intensive Care Unit after receiving a tissue plasma activator (tPA) for a stroke. You are beginning to regain your ability to speak and move your affected extremities after almost 4 hours of being unable to do so. You have lots of questions about what has happened, the medications you were given, and why you have multiple IVs and a foley catheter.

Nurse: The nurse enters the patient's room to do the 15-minute neurological check and finds that the patient has regained their ability to speak and move their extremities. The patient begins to ask the nurse questions about what happened.

You as the leader walk up to a student and begin to talk very loud while standing over the student aka "the patient". You address the following in a negative nurse-patient communication manner:

- A family member called 911 after finding you in the living room unable to speak or move and upon arriving at the ER. You were rushed to the CT scanner where it was found that you had a stroke.
- You were given tPA for the stroke and you were then brought to the NICU to keep a close eye on
- You have multiple IVs that are needed for access to give medications and needed for the CT scan.

Points to discuss:

- Negative and positive verbal and non-verbal communication
- Nurse explains from the beginning
- Nurse explains the need for IV
- Nurse does not tell what TPA is
- Nurse uses medical terms and not lay terms
- Nurse does tell the patient their location
- Nurse does not explain the need for being closely watched
- Nurse does not explain the foley
- Nurse does not tell them what to expect from here

Appendix D

Student-Led Role-Playing Exercise

Directions:

1. Divide up into groups of two. Give one student in the group a positive "nurse" and "Patient 1" scenario and give the other student a negative "nurse" and "Patient 2" scenario. Read one of the patient scenarios together and keep the nurse scenario private. The "patient" will roleplay as the helpless one asking lots of questions, while the "nurse" will roleplay as his/her scenario suggests. If there is an odd number of students, have the 3rd student observe the interaction of one group.
2. **Patient scenario** explains why in hospital if family present or not, and signs and symptoms dealing with.
   Nurse scenario states whether a negative or positive experience. The "patient" will not know which one this is. Students will each have the opportunity to role-play the nurse scenario they were given.
3. After each student has had the opportunity to role-play as the "nurse" and the "patient", then come together as a group to give feedback on how it felt to be treated in the negative and positive experience.
4. Discuss at length the positive strategies that could be done with each scenario.

Patient 1

Scenario: you were in a car accident by yourself and broke your dominant arm and left leg. You must ask for help to feed yourself. Your pain has been uncontrolled and you have not seen your doctor since yesterday morning. Currently, your pain is 9/10 in your dominant hand and 7/10 in your leg. You are constipated and nauseous. Bathroom privileges only. You have not PTO available at work.

Family: present, introduce your spouse and ask that they be included in the conversation, there are 3 children at home under the age of 12.

Patient 2

Scenario: Out of town for a work conference and had a heart attack. You will be stated on new medication and be expected to change your diet and start an exercise program. STEMI, MONA protocol, Heart Healthy Diet, and Cardiac Rehab exercise program and had a heart cath. Which you have no idea what any of this means. You are upset that salt is not on your meal trays. You do not understand why your leg is to remain still and your

back is hurting 8/10 from the position you are in. Headache from the nitro. paste on your chest.

Family: not present

Nurse

Experience: Positive interaction.

This is the 3rd 12-hour shift in a row. One of your patients needs a personal sitter but does not "qualify". Your vacation time was turned down because someone else put in that same time before you. You are having to take on 2 extra patients before help arrives in 2 hours. It is morning rounds and you need to do the initial assessment and pass medications. There is only one nurse aide on the floor.

Suggestions: Make eye contact, smile, call the patient by name, sit at eye level, use appropriate nodding, use lay terms (avoid medical terms), the tone should be calm and at an appropriate level for patient hearing, be patient and exhibit a caring attitude, be attentive to needs.

Nurse

Experience: Negative interaction.

This is the 3rd 12-hour shift in a row. One of your patients needs a personal sitter but does not "qualify". Your vacation time was turned down because someone else put in that same time before you. You are having to take on 2 extra patients before help arrives in 2 hours. It is morning rounds and you need to do the initial assessment and pass medications. There is only one nurse aide on the floor.

Suggestions: Do NOT make eye contact, stand over the patient to look down at them, roll eyes, shift weight from foot to foot, make noises to indicate in a hurry, use medical terms as much as possible, speak either too loud or too soft, talk over patient, ask questions and don't give enough time to answer.