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Improving Nurse-Patient Communication Using the Teach-Back Method

Sheila Revis Smallwood

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Improving Nurse-Patient Communication Using the Teach-Back Method

by

Sheila R. Smallwood

A capstone project submitted to the faculty of
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in partial fulfillment of the requirements for the degree of
Doctorate of Nursing Practice

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Abstract

Effective nursing communication considers health literacy, the person's ability to understand and make health decisions based on the information given. Health professionals often overestimate the health literacy of patients, thereby affecting patient outcomes. In a hospital environment, patients rate the ability of the nurse to explain things in a way patients understand by completing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) after discharge. The HCAHPS results are converted to a score which is used in a formula to determine hospital reimbursement; the lower the score, the lower the reimbursement. The purpose of this project was to improve nurse communication skills and facilitate patient understanding of care. A literature review revealed the teach-back method as a best practice strategy. Teach-back is a communication technique designed to improve patient understanding about what was said by healthcare providers. Teach-back is a way of presenting information, then asking patients to repeat what was said in their own words. An education module designed to improve nurse communication skills was implemented on a 14-bed hospitalist medical unit for the registered nurse staff (N=13). The education included content on health literacy and the teach-back method of communication. Nursing staff was surveyed before (61.5% response rate) and six weeks following (50% response rate) the educational offering, using the Health Professionals Communication Skills Scale (HP-CSS), an 18-item tool measuring empathy, informative communication, respect, and social skills. In addition, patient responses to the HCAHPS question, *the nurse explained things in a way you could understand* were compared before and after the educational offering.

Overall, the post-survey responses were lower than the pre-survey responses in each domain, indicating a decreased perception of communication by the nursing staff. The aggregate mean score for informative communication decreased from 5.01 to 4.83 ($p = 0.37$) and social skills decreased from 3.85 to 3.75 ($p = 0.87$) on the post-survey, with significant aggregate mean score decreases for respect 5.46 to 4.76 ($p < .05$) and empathy 5.32 to 4.77 ($p < .05$) post-survey. All patients discharged home from this facility receive the HCAHPS survey; the average response rate is 12%. During the pre-implementation period (September – November) 22 patients completed the survey and during the post-implementation period (January-March) only three patients completed the survey. Outcomes will be monitored as communication between nurses and patients improves over time. Education on the best practice strategy of the teach-back method of communication has been implemented for all bedside staff within the organization, including newly hired nurses. A teach-back module had been placed in the electronic learning management system for mandatory completion by all staff. With this multi-level approach to implementing teach-back, patients should have greater opportunities for understanding their care.

Keywords: health literacy and communication, patient satisfaction and nursing communication, communication with nursing and HCAHPS, and teach-back

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SECTION I

Problem Identification

As a former nurse recruiter in a large 800+ academic medical center located in the Southeast, this author was told many times by nurse applicants, “I didn’t want to be a doctor because I wanted to spend time with patients. Doctors are in the room with the patients for five minutes, but nurses are in there all the time.” It is surprising, therefore, that the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) score for *communication with nurses* within the organization was 79% (percentage of respondents who replied *always* on the Likert Scale). This was highest in the regional comparison group, yet below the state average of 81% (Medicare.gov, n.d.). Furthermore, when evaluated internally, the scores within the medicine division were 66%, among the lowest in the medical center. How could this be, when nurses say they want to spend time, which suggests communication with patients, yet some patients perceive a lack of communication in the interactions? This project manager began to assess the literature and organizational culture to better understand the reasons for the disconnection.

Healthcare Communication Literature

Several studies have been conducted to evaluate the time nurses spend with patients and the tasks performed during a shift. In 2008, Hendrich, Chow, Skierczynski, and Lu reported on a time and motion study conducted on medical-surgical nurses within 17 healthcare systems in 36 hospitals across 15 states. All nurses were asked to wear a radiofrequency identification (RFID) tag that monitored movement and location. Nurses were also given a personal digital assistant (PDA) and monitored 24-hours per day over

seven days. Nurses were randomized to two groups, one group recording all documentation-related activities throughout their shift, and the other group who stopped and recorded what they were doing when they received vibrations. The researchers found that nurses in this study spent an average of 30.08% of their time (171 minutes) in patient rooms during a 10-hour shift, with 155.8 (91.1%) of those minutes on patient care activities. Patient care activities included direct patient care, education, and nursing interventions in response to a need, however, any tasks associated with medication administration was captured separately.

The nurse-patient ratio was not reported in the study; however, if the nurse-patient ratio was 4:1, the nurse was spending as little as 38 minutes per patient providing direct patient care. Time spent per patient would decrease exponentially with higher ratios. Communication was not specifically identified as a patient care activity in this study (Hendrich et al., 2008), but since education was included in the possible 38 minutes of individual patient care, it could account for poor nurse communication scores reported by patients.

Westbrook, Duffield, and Creswick (2011) conducted a prospective observational study in Australia to analyze how nurses spend time during their shift. Data was collected on two medical and surgical wards in 2005/2006 and again in 2008 for a total of 41 months. In 2005/2006, 27 nurses were observed for 109.8 hours and in 2008, 30 nurses were observed for 81.5 hours. Nurses on the wards had a 3-4 patient assignment in 2005/2006; however, in 2008, the nurses worked in teams of three providing direct care to 10-12 patients. The researchers identified tasks nurses performed and included communication in the direct care. In 2005/2006 nurses performed 9.2 tasks per hour or

20.4% of their 8.5 hour shift in direct patient care tasks. In 2008 this significantly increased to 11.8 tasks per hour or 24.8% ($p < 0.01$) of their 8.5 hour shift in direct care. The amount of time for each direct care task decreased from 80 seconds in 2005/2006 to 76 seconds in 2008 and nurses changed tasks on average every 55 seconds. Both studies demonstrated that communication is incorporated into direct care duties which occur in short increments and not clustered into one chunk of time (Westbrook et al., 2011).

From a nursing perspective, communication occurs in each interaction. In a qualitative Iranian study, Fakhri-Movahedi, Rahnavard, Salsali, and Negarandeh (2016) studied the role and skills of nurses in patient-nurse relationships. Eleven Iranian nurses and 12 patients on medical and surgical wards in a publicly funded university hospital in Tehran were interviewed for their perspectives on their roles in nurse-patient relationships. Nurses revealed the main focus of communication was based on the patient's need, which begins before the first encounter. This was further divided into two categories, identifying the patient's needs and the nurse's communicative behaviors in the face of the patient's needs. Communication of patient's needs occurred during assessments, questioning, and monitoring of health status. Further communication of patient's need was facilitated by the patient asking about their diagnosis, test, treatments, discharge, and cost. Nurses in this study identified patient education, including discharge instructions, as an informal process. Discharge instructions were given while providing care on the day of discharge and included information on medications, follow-up appointments, and diet.

From the patient's perspective, the response of nurses when performing tasks and providing information was important and were described as communicative behaviors

(Fakhr-Movahedi et al., 2016). Communicative behaviors included caring attention, inducing calmness, obtaining trusts, and providing informal education in the face of patient's needs. According to patients, caring attention, inducing calmness, and obtaining trust was demonstrated when nurses included timely response to requests, kind and sympathetic responses, and ascertaining the response following an intervention. When communicative behaviors were demonstrated, i.e., treating patients with respect, understanding, and politeness, satisfaction scores with nursing care was high (Fakhr-Movahedi et al., 2016).

Patient's perspective was also evaluated by Jeffs et al. (2014). The researchers elicited the perspective of patients on nursing communication by analyzing interviews with patients who experienced bedside nursing handover, a formal end of report shift report between the oncoming and off going nurse, which includes the patient. The setting for this study was a teaching hospital in Toronto, Canada and included interviews of patients from a variety of units including medical, surgical, and obstetrics and gynecology. Three themes emerged from this analysis: creating space, bumping up to speed, and varying preferences. Patients reported that nurse handoff provided an opportunity for connection with their nurse. Patients appreciated being introduced to the oncoming nurse by the off-going nurse. Patients felt it was a personal touch, provided security, and valued comfort. Patients felt this space was highly valued because it created an opportunity to ask questions, provide input, and correct or clarify any erroneous information.

The second theme to emerge was bumping up to speed, a time for the oncoming nurse to receive pertinent, up-to-date information about their history and the plan of care

from the off going nurse, which patients found comforting (Jeffs et al., 2014). In addition, patients stated this was a time when they would find out information or a plan not previously shared. The third theme was the variation in patient preference for the experience. Some patients wanted an opportunity to participate, while others only wanted to listen. Patients who had been on the unit several days did not necessarily want to hear the handoff report every day. From the description of the setting, patients may have been in semi-private rooms, and a few were uncomfortable with confidential information being shared at the bedside (Jeffs et al., 2014). The researchers stated that a limitation of their study was the inconsistency of nursing practice. The average length of stay for study participants was 12 days, yet some self-reported only experiencing bedside nurse handoff twice. Of note, the length of stay for patients in this study exceeded the Canadian average length of stay of 7.4 and the United States' average of 4.5 (Organisation [sic] for Economic Co-operation and Development [OECD], 2014).

In addition to nurse handoff at shift change, communication occurs when there is a transfer of care from one area within an organization to another. Stutzman, Olson, Greulich, Abdulkadir, and Rubin (2017) evaluated the patient and family perspectives of transfer of care from operating room nurses to the ICU nurses. Family members perceived communication as the most important factor in the process. The family discussed the need for communication beginning preoperatively and continuing intra-operatively through to the recovery room. Speaking with the perioperative nurse prior to surgery made the family feel more at ease. The family liked knowing how the surgery was progressing, what time they would be able to see their loved one, and when the transfer to the ICU was to occur. Observing the nurse-to-nurse communication during

the transfer to ICU was also important in helping ease family concerns for care and increased feelings of safety. Patients and families stated that they wanted follow-up after the transfer. They wanted the nurse to know and understand the details of the patient, which decreased stress (Stutzman et al., 2017). These communication needs of patients and families may apply to any area where care is transferred post-operatively.

Health Literacy Literature

Inherent in communication is the ability to understand what is being said.

Communication is defined as “a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior” (Communication, Merriam-Webster’s online dictionary, 2017). An American Hospital Association (2003) document states that patients have the right to be involved in their care and need to understand the information provided. A patient may understand the words but the medical meaning may be different from the everyday language, i.e., pleural/plural, flare/flair, and people need to understand and comprehend. The concept of patient comprehension is known as health literacy and is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Ratzan, 2001, p. 210).

According to the Program for the International Assessment of Adult Competencies (PIAAC), only 13% of U.S. adults between ages 16-65 years demonstrated the highest level of literacy proficiency and 18% demonstrated the lowest (Institute of Education Sciences: National Center for Education Statistics, 2016). The literacy test includes reading, numeracy, and problem-solving, all of which are needed to achieve positive health (Institute of Education Sciences: National Center for Education Statistics, 2016).

The latest National Assessment of Adult Literacy (NAAL) conducted in 2003 by the National Center for Education Statistics revealed that 35% of the U.S. population had a basic or below basic health literacy rate (Institute of Education Sciences: National Center for Education Statistics, 2006). This test measures adults' ability to read and understand printed health information. Those who had basic health literacy could read the printed information and determine two reasons for a medical procedure if asymptomatic, and those below basic were able to understand fluid instructions to be followed prior to a medical test. Respondents who received Medicaid, Medicare, or were not insured were more likely to have below basic or basic health literacy proficiency. As expected, the more education, the better the health literacy; however, all educational levels were represented at the basic or below basic proficiency level. Twenty-five percent of those with some college and 12% of those with a bachelor's degree had a basic or below basic proficiency level, indicating a degree does not necessarily equate to health literacy (Institute of Education Sciences: National Center for Education Statistics, 2006).

The inability of nurses to estimate the health literacy of patients was demonstrated in a study by Dickens, Lambert, Cromwell, and Piano (2013). The researchers recruited 30 nurses and 65 patients. The patients completed the Newest Vital Sign (NVS) tool to determine their health literacy level, and nurses were asked to estimate the patient's health literacy by selecting a question that reflected the NVS categories. Nurses estimated that 19% of the patients had a high likelihood of limited health literacy when 63% of the patients had a high likelihood of limited health literacy. Additionally, nurses reported that 68% of the patients had adequate health literacy, overestimating by 22%.

Overestimating a patient's health literacy may lead one to communicate in a language the person may not understand.

In another study of nursing communication, Sayah, Williams, Pederson, Majumdar, and Johnson (2014) evaluated the use of jargon and mismatched language as the nurse educated patients with Type 2 diabetes. Medical jargon and mismatched language were defined as "words common to everyday language but used in the medical environment with different or specifically modified meaning... i.e., blood counts" (p.413). Nine nurses and 36 patients in Alberta, Canada agreed to have their encounters taped and analyzed. After the encounter, patients also agreed to complete an additional survey including a health literacy assessment. Results revealed that medical jargon was used sometimes (19%) and often (17%) by nurses during patient encounters. Mismatch language was used sometimes (33%) and often (25%). Nurses used medical jargon (39%) and mismatched language (65%) with patients who had adequate literacy and used medical jargon (31%) and mismatched language (46%) with those with low health literacy. Effective nurse-patient communication requires the patient to understand not only the words but the meaning.

In addition to the use of jargon, Sayah et al. (2014) evaluated whether the communication loop was used while providing the education. The communication loop consisted of repetition, clarification, asking for understanding, checking for understanding, and seeking the patient's perspective. Results revealed that nurses completed the communication loop during four out of 36 patient encounters (11%). Of the four encounters, three patients had adequate literacy, and one had low literacy (Sayah et al., 2014). Of the five steps in the communication loop, the most commonly used by

nurses were clarification (58%) and repetition of health information (33%). The least used components of the communication loop were checking for understanding (81% never used) and asking for understanding (42% never used). The literature on communication and health literacy shows the importance of clear communication techniques to patient and family outcomes, particularly satisfaction with care.

SECTION II

Needs Assessment

As important as communication is to patients and nurses, it is equally important to the financial solvency of healthcare organizations. Prior to 2013, Medicare funds reimbursed patient care services based on the quantity of services provided; however, it changed in 2010 when The Affordable Care Act established the Hospital Value Based Purchasing Program (VBP) (Department of Health and Human Services Centers for Medicare & Medicaid Services, 2015). This program reimburses for the quality of the service provided and is determined by how well an organization “performs on each measure or how much they improve their performance on each measure compared to their performance during a baseline period” (Department of Health and Human Services Centers for Medicare & Medicaid Services, 2015, p. 1). The four measures that determine reimbursement are patient and caregiver-centered experience of care/care coordination, safety, clinical care efficiency, and cost reduction (Department of Health and Human Services Centers for Medicare & Medicaid Services, 2015).

Patient and caregiver-centered experience of care/care coordination, better known as HCAHPS, makes up 30% of the VBP incentives hospitals receive and consists of eight domains (a) communication with doctors, (b) communication with nurses, (c) responsiveness of hospital staff, (d) pain management, (e) communication about medication, (f) cleanliness/quietness of hospital environment, (g) discharge information, and (h) overall rating (Department of Health and Human Services Centers for Medicare & Medicaid Services, 2015). Surveys are sent to patients by Press Ganey, one of the largest vendors for HCAHPS. Patients score the domains using a Likert Scale of Never,

sometimes, usually, and always. Press Ganey provides CMS with information for each domain and based on the top box scores, the percentage of always responses, the hospital receives a Total Performance Score (TPS) to determine their reimbursement payment. The higher the TPS, the higher the reimbursement; the lower the score, the lower the amount of reimbursement payment with the possibility of a negative reimbursement of up to 2%, which could ultimately have a negative impact on any organization (Department of Health and Human Services Centers for Medicare & Medicaid Services, 2015).

CMS provides a percentile ranking and star rating for each domain of the HCAHPS survey and publicly reports this information on the Medicare.gov Hospital Compare website (Medicare.gov, n.d.). Many hospitals set targets based on the CMS goals while others use their HCAHPS vendor's dataset to establish internal goals (Department of Health and Human Services Centers for Medicare & Medicaid Services, 2015). This academic medical center uses the Press Ganey national database to assist in setting targets for the 75th percentile (performing better than 75% of other organizations) and a stretch goal at the 90th percentile (performing better than 90% of other organizations). The target and stretch goal for each of the domains are: communication with doctors (80.44; 88.51), communication with nurses (78.52; 86.68), responsiveness of hospital staff (65.08; 80.35), pain management (70.20; 78.46), communication about medication (63.37; 73.66), cleanliness/quietness of hospital environment (65.60; 79.00), discharge information (86.60; 91.63), and overall rating (70.23; 84.58). Five of the eight domains specifically rely on communication to meet the goals. The Press Ganey (2013), discussed the importance of the category communication with nurses and its impact on

the other seven domains and stated what nurses do impacts all aspects of each of these measures within the patient satisfaction domain.

To better understand what nurses do, and how it impacts nurse-patient/family communication, this project manager shadowed direct bedside nurses at various times during several shifts. The shadowing took place on a medicine unit with a mixture of Hospitalists and Advanced Practice Providers caring for the patients. The unit is staffed with Registered Nurses (RN) and Certified Nursing Assistants (CNA). The nurses take care of five to six patients, assisted by a CNA who can have as many as seven patients. There is also a charge nurse who takes patients infrequently. The nurses vary in experience with 48% of the staff hired within the last year (D. Clark, personal communication, June 6, 2017). The nurses shadowed by this project director had between three months to over 10 years of nursing experience. The shadow experiences took place during several patient interactions including admissions, bedside shift report, Structured Interdisciplinary Bedside Report (SIBR), morning medications, reassessments of patients, other scheduled medication passes, and discharge.

Communication effectiveness observed during the shadowing experiences varied by nurse and nursing experience; more experience appeared to influence better communication. The nurses with less experience used more medical jargon than the more experienced nurses. When a patient asked one of the experienced nurses a question, she immediately asked: “what concerns you about that?” The nurse listened to the concerns, answered the question, and, if out of her scope of practice, stated she would discuss with the provider. The newly licensed nurse was observed misunderstanding what the patient was *really* asking. This resulted in asking the provider to come to the

bedside to answer questions a more experienced nurse would be able to answer without assistance.

During the admission process, the nurse was observed asking all the required questions and giving information on equipment used for continuous monitoring. There was some orientation to the room, and patient questions were answered, but no real orientation was offered regarding unit operations, i.e., bedside shift report, the At Your Request (AYR) meal ordering process, or the daily SIBR which takes place every day with the entire primary team. One patient stated she needed to have a bedside commode because of incontinence and the observed nurse did not address the issue or explain that one would be ordered for her.

Medication administration often occurred with no identification or explanation of the drug being given, or its indications and side effects. The nurses handed the patient a cup of pills and water. When hanging antibiotics, again no explanation was observed. One discussion was observed when an elderly patient insisted he took five times the dose of medication the nurse was giving him. The nurse acted as if she didn't believe him and asked to have his wife bring the medication when she visited later that day. The patient's wife brought the medication, and the patient was correct; the nurse offered no apology and stated she would discuss the change in medication dose with the MD before the next dose.

Another observed patient had a chronic disease that left him with contractures and an inability to verbally respond. He had a tracheostomy and was receiving bolus feedings via a Percutaneous Endoscopic Gastrostomy (PEG) tube. The less experienced nurse communicated approximately half of what was being done, did not tell the patient about

administering a bolus feeding, and did not talk to the patient as the feeding was administered.

As bedside nurse-to-nurse shift report was observed, nurses talked to each other and not to the patient. Medical jargon was used with no attempt to explain to the patient what any of it meant. One patient tried to speak about the possible need for a nicotine patch, but the nurses did not listen, spoke over him, and eventually, the patient stopped attempting to participate. If the patient was included, it was at the end and cursory. The bedside nurse-to-nurse shift report was observed as a nurse-to-nurse handoff, not a bedside report involving the patient.

This hospital utilizes an electronic record; the After Visit Summary (AVS) is information about the patient's hospital course and discharge instructions (identified by the nurse), including medications and follow up appointments. The AVS is printed and given to the patient during the discharge process. The AVS can be lengthy; however, nurses highlight important information for the patient's benefit. Nurses were observed highlighting all the medications, future appointments, and any other pertinent information. During the discharge process, the nurses were observed reviewing the AVS in detail and reading information that was deemed particularly important for the patient to know. Often, nurses stated it was too much to read at this time and instructed the patient to read it when they got home. There was no attempt to ascertain the patient's ability to read and understand printed health materials. One new graduate nurse was observed sitting down beside the patient's family and reviewing each page. Some medical jargon was used without verifying if the patient understood, i.e., low sodium diet vs. low salt diet.

This unit is managed by the hospitalist; therefore, all appointments are made with other providers. Nurses were observed reviewing the follow-up appointments recommended by the physician, but there was no clear explanation about who was responsible for making the appointment. The AVS lists all medications in a table so patients can see what and when the next dose of medication is to be taken. All the nurses observed starred the columns for a.m. and p.m. without telling the patient specifically what time to take the next dose. One of the experienced nurses was observed making sure the patient understood the instructions before leaving, asking the patient to repeat instructions. During each nurse-patient interaction, the project manager observed missed opportunities for communication clarity.

The Medicine Unit where the nurses were shadowed had some of the lowest HCAHPS scores within the organization. The overall *Communication with Nursing* score has steadily declined from a high of 77.3% in fiscal year (FY) 2015 to a low of 64.0% in FY17, placing this unit in the lower 5th percentile, far below the target and stretch goal.

The *Communication with Nursing* category is comprised of three questions: “during this hospitalization how often did the nurses (a) treat you with courtesy and respect (b) listened carefully to you, and (c) explained things in a way you could understand (Hospital Consumer Assessment of Healthcare Providers and Services [HCAHPS], 2017, p. 1). As observed by the project manager, patients were often not listened to and did not appear to always understand what was said. Patient-nurse communication relies on nurses to share information in such a way that patients are encouraged to actively participate and comprehend the information at the end of the exchange. The scores on this unit for *the nurse explained things in a way you could*

understand have decreased from 75.4% in FY15 to 64% in FY17. To improve the patient experience, this unit was designated as the unit for implementation of a best practice designed to improve nurse-patient communication.

SWOT Analysis

An analysis of the strengths, weakness, opportunities, and threats (SWOT) was completed and is depicted in Figure 1. A SWOT analysis is a simple, yet effective tool for providing a sense of direction for the project (Zaccagnini & White, 2017).

<p style="text-align: center;">Strengths</p> <p>Staff willingness to try something new</p> <p>Management Support</p> <p>Available HCHAPS data</p> <p>Patient Experience willing to assist with project</p>	<p style="text-align: center;">Weaknesses</p> <p>Majority of staff members are new to the organization</p> <p>HCHAPS may not be the best tool available to measure patient's satisfaction with communication with nurses</p> <p>HCHAPS only captures a certain percentage of patients</p> <p>Satisfied patients may not return the HCHAPS survey</p>
<p style="text-align: center;">Opportunities</p> <p>Finding another tool to measure patient satisfaction with communication with nurses</p>	<p style="text-align: center;">Threats</p> <p>Nurse-patient ratios</p> <p>Inability to come to class</p>

Figure 1. SWOT Analysis

Literature Review for Best Practice Strategy

A literature search was done in Proquest, Google Scholar, and Ebsco Host databases. Keywords used in the search were patient satisfaction and nursing communication, communication with nursing and HCAHPS, nurse patient communication, communication and patient perspective, communication failure, health literacy and communication, health literacy and HCAHPS, health literacy and teach-back, health literacy and communication failure, nurse communication and active listening, nurse communication and Ask me 3™, health literacy, teach-back, and Ask me 3. The search for articles with these terms, limited to scholarly journals, and English language yielded more than 50,000 articles; therefore, the dates were limited to 2012-2017 and adult populations. A review of research articles to determine best practices to improve nursing communication yielded a smaller pool of potential articles, so research was reviewed with publication dates 2007-2017.

Communication Strategies

After an extensive review of the literature, solutions that focused on improving nurse-patient communication identified the need to include health literacy in any improvement intervention. In addition, the literature identified four major strategies for improving nurse-patient communication: implementing the health literacy universal precautions toolkit in totality or two of the methods in the tool kit, teach-back and/or Ask Me 3™ techniques, and communication skills training to health care providers. The preponderance of literature recommended implementing the teach-back method; however, all four interventions were reviewed for consideration.

Health Literacy Universal Precautions

The Agency for Healthcare Research and Quality [AHRQ] (2017) advocates the adoption of Universal Health Literacy Precautions for all patients. Universal precautions create an environment where all patients receive equal communication and treatment regardless of health literacy level.

The precautions are aimed at:

- Simplifying communication with and confirming comprehension for all patients, so that the risk of miscommunication is minimized.
- Making the office environment and health care system easier to navigate.
- Supporting patients' efforts to improve their health. (AHRQ, 2017, para. 2)

To facilitate the implementation, the AHRQ created a health literacy toolkit for use by nurses and other organizational leaders who want to create a culture change. The toolkit can be used in its entirety or individual tools can also be selected and implemented.

Tools in the kit include behavioral and specific communication skill strategies to improve spoken and written communication. There are also strategies to address self-management and empowerment for patients. Communication behaviors include forming an interpersonal relationship by greeting the patient warmly, making eye contact, demonstrating active listening, and inviting patient participation by encouraging questions. Oral communication skills include using jargon-free terminology, repeating back the patient's words, using the teach-back method, and answering questions (Agency for Healthcare Research and Quality [AHRQ], 2015a).

When the toolkit was tested, Dewalt et al. (2011) noted that utilization of the tools varied with learning styles. Some read the background for understanding of the details of

the process, and others glanced over the material to get the gist of the information for immediate implementation. There are worksheets in the toolkit, and it was noted those who read to get the gist did not realize there were worksheets to help with implementation. The authors concluded that two months was not long enough to make an organizational change (Dewalt et al., 2011).

As part of an 18-month leadership program in the Sigma Theta Tau International Maternal-Child Health Nurse Leadership Academy, participants developed and implemented a multidisciplinary team project. Stikes, Arterberry, and Logsdon (2015) implemented the Health Literacy Universal toolkit on a Maternal-Infant unit at a 400-bed academic medical center. The researchers wanted to demonstrate that using Health Literacy Universal Precautions would improve HCAHPS in the *Communication with Nurses* domain. The researchers implemented all aspects of the toolkit beginning with the development of an infrastructure to evaluate and identify printed materials that meet health literacy standards. In addition to evaluating printed materials, the researchers conducted a health literacy assessment of their patients. Finally, the researchers provided a one-day intensive continuing education program focusing on Health Literacy including the use of plain language, Teach-back method, and Ask Me 3™ methods. Eighty-one participants, including nurses, registered dietitians, and patient advocates, attended the educational program. In addition, health literacy content was included in the annual nursing competencies for staff on the Maternal-Infant Unit.

Stikes et al. (2015) reported that the HCAHPS scores in the *Communication with Nurses* domain all improved, as a result of the intensive education, from a mean of 80% (the year before implementation) to 86.2% (the year after this implementation). The

question, *do nurses explain in a way you understand*, improved from 77.53% to 89.94% and *satisfaction with discharge information* improved from 86.14% to 92.8%. This approach requires the commitment of the unit staff and organization leadership to change the culture of communication. Changing written materials and teaching staff communication techniques which meet any patient's health literacy level was found to be costly and required many resources. Additionally, this approach required buy-in from stakeholders and time to develop, implement, and evaluate (Stikes et al., 2015).

Ask Me 3™

The AHRQ health literacy toolkit identifies Ask Me 3™ as a strategy to improve communication (Agency for Healthcare Research and Quality, 2015b). Ask Me 3™ is a program developed by the Partnership for Clear Health Communication at the Pfizer pharmaceutical company that teaches patients to ask their healthcare providers three questions during each visit “what is my main problem, what do I need to do, and why is it important for me to do this”? This program

- “assists patients in becoming more involved in their health care.
- organizes the provider-patient conversation.
- focuses discussion on the answers to key questions.
- ensures that patients acquire the information they need to take care of their health” (National Patient Safety Foundation [NPSF], 2016, p. 39).

Michalopoulou, Falzarano, Arfken, and Rosenberg (2010) evaluated if giving the Ask Me 3™ pamphlet to low-income African American patients in an inner city medicine clinic in Detroit, MI would improve patient satisfaction and perception of physician cultural competence. Of the 64 participants, 32 received an Ask Me 3™ pamphlet during the

registration process and 32 in the control group did not receive the pamphlet. Some patients saw their regular primary care physician while some saw someone unfamiliar. After the visit with the physician, all participants completed the Perceived Cultural Competency Measure survey, and the 32 who received the pamphlet were interviewed about their use of the pamphlet.

There was no statistical difference of perceived cultural competency between the two groups. The Ask Me 3™ pamphlet was reported to be helpful (93%), used (93%), and 91% of patients receiving the pamphlet reported knowing more about their medical condition or illness after the visit. A limitation of this study was that randomly assigned patients did not always see their primary care physician (48.2%). Patient satisfaction was statistically different comparing those who saw their primary care physician ($p = .014$) versus those who saw a random physician ($p = .027$). Furthermore, the authors did not have information on the understanding and knowledge of patients not receiving the pamphlet (Michalopoulou et al., 2010).

A benefit to the Ask Me 3™ approach is the level of involvement of the patient. Patients are encouraged to ask the physician three specific questions; thereby, initiating relevant dialogue and communication. The limitation of this approach is it places the burden of communication on the patient. If the patient does not ask the questions, there is the possibility they may leave without the necessary information for positive outcomes. Ask Me 3™ is often paired with Teach-back to ensure the patient and nurse give and receive important information (Dickens et al., 2013; Dickens & Piano, 2013).

Teach-Back

Teach-back is a communication technique designed to improve patient understanding about what was said (AHRQ, 2017). Teach-back is a way of presenting information, then asking patients to repeat what was said in their own words. It should not feel like a quiz, but a confirmation of what was understood. If the patient is unable to explain what was said or has additional questions, it gives healthcare providers an additional opportunity to evaluate material needing to be re-explained before moving to additional concepts or ending the conversation (AHRQ, 2017).

Techniques related to teach-back include speaking in plain language and planning an approach for asking patients to repeat the information. Nurses should explain the reason for the teach-back is to make sure the nurse covered the content, not to test the knowledge of the patient. Nurses should provide information in small increments so that patients can understand and explain what was covered, known as *chunk and check* (Agency for Healthcare Research and Quality, 2015a). The nurse should check for understanding throughout the discussion, not wait until the end, *chunking* the information into smaller pieces for better patient clarity. If the patient is not able to correctly explain the information back to the nurse, one should clarify and check again, repeating the information using a different technique or description. The patient should not repeat the information back verbatim but use familiar language that shows the information was understood. Finally, if the information is a skill, verbalization and skill demonstration should be used to ascertain patient understanding (Agency for Healthcare Research and Quality [AHRQ], 2015c).

Discharge instruction. Teach-back has been studied in many settings for a variety of reasons, including increasing retention of knowledge, reducing readmissions, and improving patient satisfaction. Griffey et al. (2015) evaluated the impact of teach-back on comprehension of discharge instructions and patient satisfaction on low literacy patients in an urban academic emergency department (ED) and level I trauma center. Patients who agreed to participate were selected after scoring six or less on the Rapid Estimate of Adult Literacy in Medicine-Revised (REALM-R). Patients were randomized to either a teach-back group or a standard discharge instructions group. For those randomized to the teach-back group, the discharge instructions and the patient's explanation were recorded by a research assistant. Following the discharge, patients were questioned about their satisfaction with the care and the discharge instructions. Patients were also asked about their comprehension of the instructions.

Of the 408 eligible patients, 254 completed the protocol, 127 in both the teach-back and standard discharge instruction groups (Griffey et al., 2015). Comprehension of post-ED care ($p < 0.02$), post-ED self-care ($p < 0.0001$) and post-ED medications ($p = 0.054$) was higher for the teach-back group; however, there was no difference in patient satisfaction. Although, this study did not demonstrate that the use of teach-back improved patient satisfaction, it did significantly improve comprehension of discharge instructions. The researchers evaluated patient satisfaction immediately after discharge from the ED, yet HCAHPS surveys are sent to patients 48 hours to six weeks after hospital discharge (Centers for Medicare and Medicaid Services [CMS], 2014). Unfortunately, patients who are seen in the ED do not receive a survey; therefore, it is

unknown if satisfaction remains high once the patient leaves the ED and puts the instructions into practice.

Adherence to treatment plan. Negarandeh, Mahmoodi, Noktehdan, Heshmat, and Shakibazadeh (2013) evaluated the effect of teach-back and pictorial image strategies on knowledge, medication adherence, and dietary adherence in patients with Type 2 diabetes who scored low on health literacy in Saqqez, Iran. One hundred thirty-five patients identified as having low literacy on The Test of Functional Health Literacy in Adults (TOFHLA) were randomized to receive identical diabetes education via teach-back, pictorial image education, or usual diabetes education. Participants in the teach-back and pictorial image groups received individual diabetes education, 20-minute sessions weekly for three weeks. The usual care group had medications prescribed by an endocrinologist and were given a brochure on diabetes control and time with the community health nurse to answer any questions. For consistency, the community health nurse taught all three groups.

Diabetes knowledge, medication adherence, and dietary regimen adherence were evaluated before and six weeks after the intervention. While there were no differences between the intervention groups, the difference between the both intervention groups and the control group was significant ($p < .05$) (Negarandeh et al., 2013). This study demonstrated improved knowledge, retention of information, and adherence to a diabetes regimen in those patients identified as having low health literacy using teach-back and pictorial images. Inherent in this success is the improved comprehension of information by the patient.

Comprehension may result in decreased hospital readmissions. Patients who adhere to medication and dietary regimens may have better control of their disease process, decreasing hospital readmissions. Peter et al. (2015) implemented a teach-back initiative to decrease readmissions for patients with heart failure (HF). The nursing leaders at this 951-bed Magnet facility identified a higher than desired 30-day readmission rate of patients with heart failure. Assessment of the problem included staff observation during patient teaching and inconsistencies in practice were identified (Peter et al., 2015). While education was often offered at time of discharge, written materials were not provided, key learners or care partners were not identified, and nurses did not attempt to ascertain the learning style of the patient. Furthermore, patient health literacy was not assessed, or patient ability to understand discharge instructions. A patient and family caregiver education group identified teach-back as a strategy to improve patient discharge education and planned a pilot project on an adult medicine unit (Peter et al., 2015).

To facilitate a successful pilot, staff was provided a 20-minute online module to discuss the principles of teach-back including patient simulation videos. In addition, unit-based educators, RN champions, and leaders in other disciplines attended an additional two-hour train the trainer workshop (Peter et al., 2015).

Upon implementation, the education team identified four questions to be asked daily to assess the key learner's knowledge of the diuretic, diet, daily weight routine, and symptoms of HF (Peter et al., 2015). The key learners responded correctly 100% by discharge; however, this technique was found to be redundant and did not incorporate adult learning theories. With further refinement by the team, a standard three-day work

process for the HF patients was created (Peter et al., 2015). Instead of the same questions asked each day, the questions were revised to include three domains of learning, knowledge base on day one, attitudes on day two, and behaviors on day three. The medication question evolved from “what is the name of your water pill” to “what is the name of your water pill/diuretic” on day one; “why is it important to take your water pill every day” on day two; and “how will you remember to take your water pill every day” on day three (Peter et al., 2015). Changes were also made for questions about diet, weights, and symptoms of HF. When challenges were identified, i.e., the patient was unable to correctly answer a question, was uninterested in participating in his care, or refused to modify dietary habits, the physician and case manager were notified so appropriate discharge plans could be initiated. Finally, patient education was documented in an electronic multidisciplinary progress note. The readmission rates for patients on the pilot unit over a year decreased from 28.2% to 14% (50%). In addition, the length of stay for the 2nd hospitalization for patients who received teach-back was 5.16 days compared to 6.61 days for those who did not. The success of the pilot led to the development of a teach-back order set to be initiated on all newly diagnosed HF patients (Peter et al., 2015). This study demonstrated the benefits of standardizing staff education and a teach-back workflow for patients with HF. It also highlighted the importance of utilizing adult learning principles in developing patient education.

Readmission rates. Green, Dearmon, and Taggart (2015) implemented a quality improvement project to improve the transition to home and decrease readmission rates for veterans after a total joint replacement (TJR). An interdisciplinary process improvement team evaluated the hospital processes for patients admitted for total joint replacement and

found current practices did not reflect best practices. Discharge teaching was done on the day of discharge instead of throughout the hospitalization, and there was no standardized care plan. In addition, post-discharge telephone calls were performed by nurses unfamiliar with post-surgical protocols and the patients, and the scripted call asked no specific questions about the patient's surgery or perceived post-surgical needs. Following this assessment, the process improvement team developed a standardized discharge protocol including an educational packet, use of the teach-back method, and a modified post-discharge follow up (Green et al., 2015).

The discharge education packet included all information needed from each discipline and was standardized to include instructions from the day of admission through last-minute instruction before leaving the hospital. All 30 nurses on the 32 bed medical-surgical unit received teach-back education followed with an observation by a monitor (Green et al., 2015). During the first month of the pilot, the nurses did teach-back for nine of the 10 patients discharged. The post-discharge follow-up calls were done by a Clinical Nurse Specialist (CNS) or the orthopedic nurse liaison.

Following implementation of the pilot, re-admission rates dropped 36% (Green et al., 2015). The post-discharge phone log was evaluated for comprehension of discharge instructions. Green et al. (2015) stated that of the 27 patients contacted by phone, there was a high frequency of patients who had additional questions, validating the need to continue this initiative. The study demonstrated the success of teach-back method and the need for reinforcement of the strategies once implemented (Green et al., 2015). One month after implementation, there was a change in clinical management and a declining

use of teach-back, forcing the project leader to spend additional time on the unit reviewing teach-back and its importance for sustainability.

Readmission rates and patient satisfaction. Teach-back was also used in a five-month quality improvement project by Ross, Roberts, Taggart, and Patronas (2017) to decrease readmission rates and improve HCAHPS patient satisfaction scores for stroke patients. A nursing unit within a 689 bed Joint Commission Certified stroke center was the setting for the project. Teach-back education was provided to staff nurses by the project coordinator, the neuroscience nurse educator, and unit educator. The unit educator periodically provided teach-back education to staff during implementation as well. A discharge telephone call within 72 hours of discharge was made by the project coordinator and neuroscience division team leaders. HCAHPS patient satisfaction scores three months after implementation of the project improved from 69.5% to 79.9% ($p < .05$) and there was a 10% reduction in readmission rates. The discharge phone calls enabled timely feedback to staff on successes of education and opportunities for improvements, supporting the need for periodic teach-back education by the unit educator.

Centrella-Nigro and Alexander (2017) implemented teach-back on a nursing unit to determine its impact on the seven patient education questions on the HCAHPS survey. The researchers conducted a quasi-experimental study on two medical units. The researchers provided a mandatory one-hour teach-back class to all permanent staff (N=24) on one unit, and nurses received no education but continued with standard care on the control unit. Nurses on both units completed a pre-survey and one-month post-survey about the teach-back method which measured their knowledge, attitude, and

beliefs of the practice. HCAHPS data was also analyzed for improvement following the completion of teach-back education (Centrella-Nigro & Alexander, 2017).

HCAHPS data was analyzed for six months before the implementation and one year after the final classes. There was a statistically significant difference ($p = .025$) for only one of the seven questions measured, *tell me what the new medicine was for*. Scores for the control unit also improved; results of the nurses' post-scores revealed strong support for the use of teach-back. Of the three questions about teach-back, there was a significant improvement in knowledge of teach-back ($p = .025$) (Centrella-Nigro & Alexander, 2017). Although nurses supported the use of teach-back in their practice, they reported not having sufficient time to implement fully. Although nurses were aware of the pre-and post-survey, they were unaware of the expectation that teach-back would positively impact HCAHPS. This study highlights the difference between a research study and a quality initiative. Quality improvement initiatives implementing teach-back methods included follow-up by the project manager and others to facilitate incorporation of the best practice method into the nurse's high standard of clinical care.

Communication Skills Training

In addition to follow up by the project manager, inherent in any strategy is the need to develop staff education on communication. Khodadadi, Ebrahimi, Moghaddasian, and Babapour (2012) evaluated communication skills training on quality of care, self-efficacy, job satisfaction, and communication skills of nurses in hospitals of Tabriz, Iran. The researchers randomized 73 nurses on internal medicine and surgical wards to either an experimental group ($n = 42$) who received formal communication education or a control group ($n = 31$). Prior to implementation of the intervention, the

nurses completed questionnaires to measure communication skills, self-efficacy, and job satisfaction.

For two months, the researchers gave the intervention group lectures and educational pamphlets about communication. It is unclear how many classes and pamphlets were provided; however, the control group received none. Post-intervention results revealed that communication skills and quality of care improved following the intervention. Communication skills were measured via a questionnaire developed by Takahashi and Kosaka in 2003 (as cited in Khodadadi et al., 2012) and the higher the score, the higher the level of communication skills. Pre-survey scores for communication were the same for both groups; however, they were significantly different after the intervention. The communication skills scores for the intervention group was 86.80 compared to 81.06 for the control group ($p = 0.008$).

Quality of care also improved following the intervention (Khodadadi et al., 2012). One hundred sixty patients were surveyed for their perspective on the quality of care pre and post intervention. The questionnaire asked patients to evaluate the quality of care on a Likert Scale and the higher the score, the better the quality of care. The quality of care for the experimental group post-intervention was 81.57 compared to 77.80 for the control group ($p = 0.018$). This study demonstrated that communication training could impact not only communication skills but may translate into improved quality of care from the patient's perspective.

Summary

The review of literature confirms the problems associated with communication between patients and nurses as well as improvement strategies. Problems identified were

the lack of time dedicated to communication unrelated to patient activities, the perceptions of the nurse and patients, and the health literacy of patients (Fakhr-Movahedi et al., 2016; Hendrich et al., 2008; Jeffs et al., 2014; Westbrook et al., 2011). Nurses perceive communication was occurring during each patient interaction; however, the amount of time spent with patients is often limited. Literature revealed nurses spend less than 45-minutes during each shift with patients, not related to direct care activities (Westbrook et al., 2011). Patients' perceived communication was occurring when the nurse demonstrated caring in and during nurse-to-nurse handoffs (Jeffs et al., 2014). Bedside shift reporting when the nurses involve the patient was an opportunity for effective communication.

Effective communication occurs when the patient can understand what is said and can make health care decisions based on their comprehension. The literature reveals nurses often overestimate the health literacy of patients, and patients fail to indicate their comprehension of the information (Dickens et al., 2013). A lack of understanding has been associated with poor patient outcomes and dissatisfaction with communication with nurses of the HCAHPS. It is incumbent on the nurse to ensure patient understanding of information to improve patient outcomes and their satisfaction with communication.

The literature revealed several strategies to improve communication skills of healthcare providers: implementing the health literacy universal precautions toolkit in totality or two of the methods in the tool kit, teach-back and/or Ask Me 3™ techniques, and communication skills training (AHRQ, 2017; Stikes et al., 2015). Implementing the health literacy universal toolkit in its totality is an organizational endeavor; therefore, impractical for a DNP project. Ask Me 3™ puts the onus for communication on the

patient by requiring the patient to ask the nurse three questions about the patient's plan of care (AHRQ, 2017). Teach-back was a strategy that has been identified as successful for healthcare providers (AHRQ, 2017; Centrella-Nigro & Alexander, 2017; Green et al., 2015; Peter et al., 2015). Teaching the nurse to give jargon-free information, in small chunks, and to check for understanding once given, was ideal for a DNP project. A communication skills course is also comprehensive; however, the organization would only allot an hour for whatever intervention was implemented. Developing a course focusing on teach-back that included some information on health literacy was ideal for a DNP project.

SECTION III

Theoretical Framework

Dr. Jean Watson's Theory of Caring Science (2008) guided this project. Watson's theory is based on a relational ontology, with relationship caring seen as essential for healing. Relationships are important for the health of the patient, the community, and the practitioner. Building an authentic caring helping-trusting relationship with others should be a core professional practice. The core aspects of the theory are relational caring, Caritas Processes, the transpersonal caring moment, caring as consciousness, and caring-healing modalities (2008). A caring relationship is developed when one feels compassion and awareness of one's own and others' dilemmas. It is being authentically present, listening and hearing others. It is connecting with others on a deeper humane level. A caring relationship is about being self-aware in any caring situation. Watson (2008) believes that a transpersonal caring relationship heals body/mind/spirit, more than external interventions. She further states that this caring relationship should extend to patient education, recognizing that learning is more than receiving information, but occurs in the context of the relationship between those involved in the process (Watson, 2008).

Transpersonal Caring Relationship

A transpersonal caring relationship uses the whole self, not just the physical. According to Watson (2012), authentic presence is facilitated by stopping before entering the room, grounding oneself, becoming balanced and centered, setting an intention to enter into another's space, and being open to the possibilities of miracles. It is opening oneself up to another's energy and seeing the spirit behind the person. Watson (2012)

states transpersonal relationships are guided by *caritas* consciousness, an awareness of the subjective inner life and spirit of the other. The nurse makes a spirit-to-spirit connection with the person, creating a new energy phenomenon called a *caritas* field.

It is during this interaction that the nurse is able to see and hear all verbal and nonverbal cues and decipher what is most important to the person, respecting and honoring their wishes, and preferences. Authentic presence helps the nurse to read the environment and stay within the person's frame of reference. The nurse lets go of personal ego and gives heart-centered healing care. The nurse is fully in the moment with the person and the care may be more fulfilling, healing, life giving, and receiving (Watson, 2008; 2012). It is during these moments that genuine teaching and learning can occur.

Communication with empathy embodies Dr. Watson's concepts of heart-centered healing. Empathy is defined as:

the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner. (Empathy, Merriam-Webster's online dictionary, 2017).

Caritas Process™ 7 challenges the nurse to “Engage in Genuine Teaching-Learning Experience that Attends to Unity of Being and Subjective Meaning—Attempting to Stay Within the Other's Frame of Reference” (Watson, 2008, p. 125). In addition to being fully present with the patient, education changes from giving information to meeting the person where they are. It is understanding and adapting the education to the patient's

level of education and experience. The nurse needs to be attentive to the patient's mood and readiness to learn, tapping into the person's feelings and perceptions. It requires thoughtful and intentional planning and implementation of the education (Watson, 2008). It is timing the education to coincide with the readiness of the patient, not waiting until the day of discharge to provide all information.

Conceptual Theoretical Empirical Structure

Watson's Theory of Caring will guide the development and implementation of the communication class for the nursing staff (see Figure 2). The class will provide didactic information on health literacy and its effect on patient understanding, how to communicate empathetically, and demonstrations of the teach-back technique.

Jean Watson's Theory of Caring Science

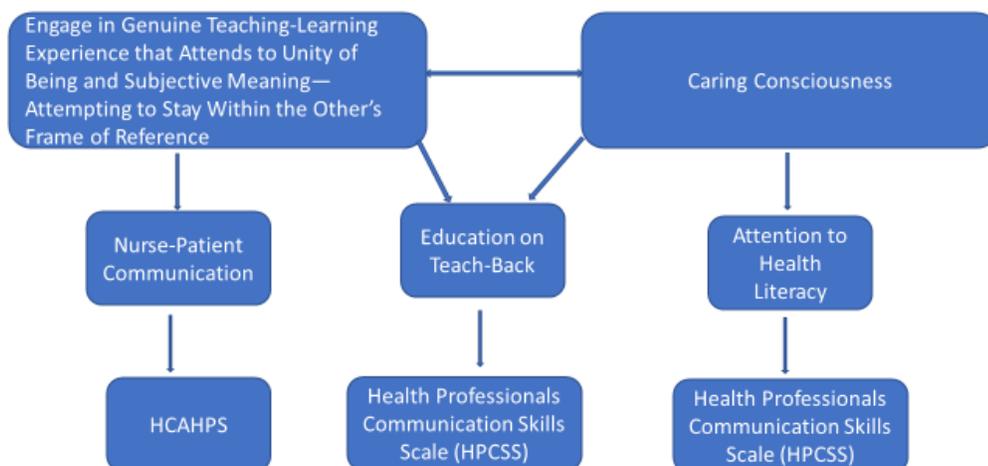


Figure 2. Improving Communication Using Jean Watson CTE

Timeline

A Gantt chart was used to describe the timeline of the project (Figure 3). A GANTT chart is a mechanism to outline steps in the process with due dates. The chart illustrates parallel processes of completed, impending and future tasks. It is often used as a mechanism for keeping projects on task (Zaccagnini & White, 2017).

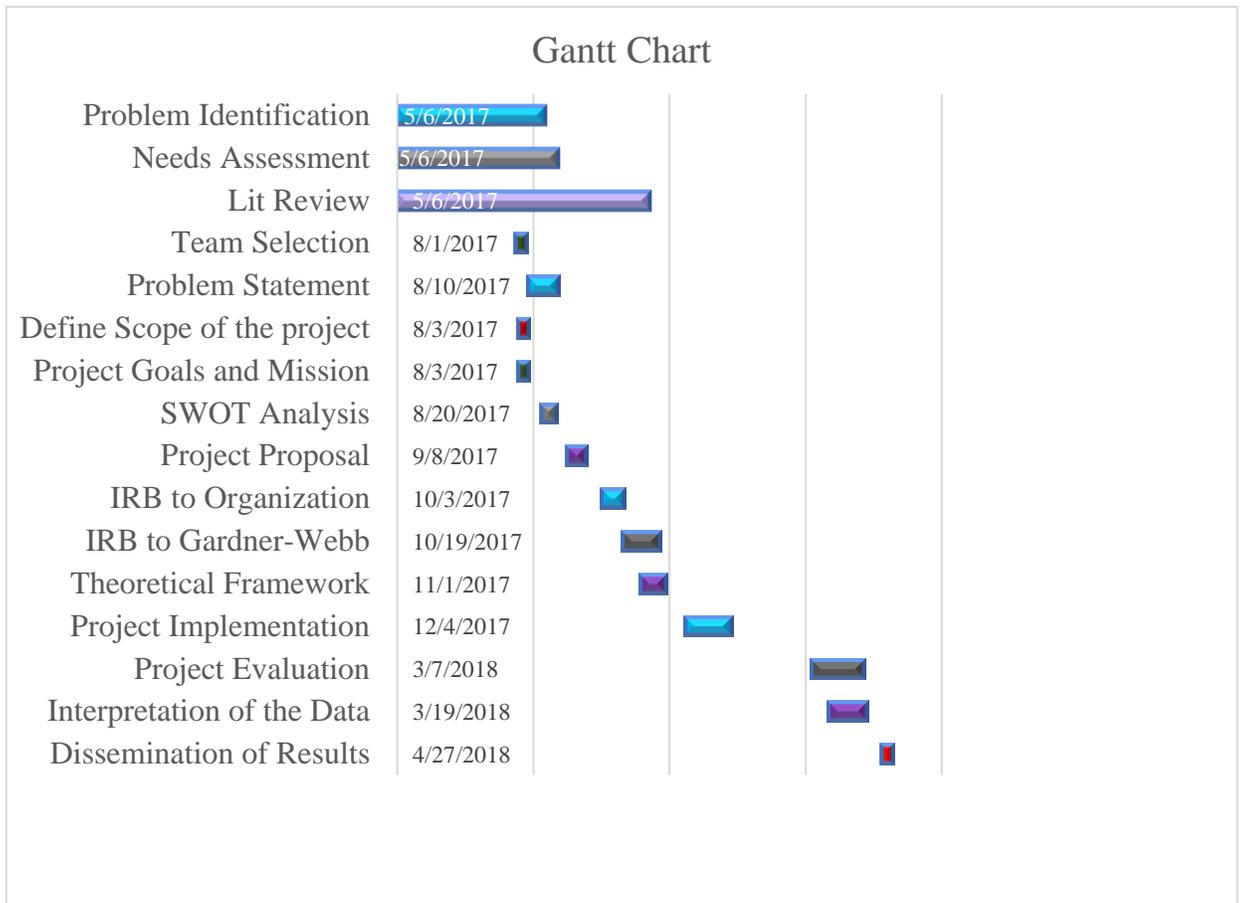


Figure 3. Gantt Chart

SECTION IV

Goal and Mission

This project will improve the patient experience by enhancing nurse-patient communication. The overall *Communication with Nursing* score has steadily declined from a high of 77.3% in fiscal year (FY) 2015 to a low of 64.0% in FY17. Patient's understanding of nurse communication as reported on the HCAHPS revealed an overall score for the academic medical center at 79% and the medicine division 66%. Discharged patients responded that nurses on the medicine division's hospitalist unit explained in a way they understood 60.7% during FY17. To assist nurses in enhancing the patient experience, a class on using the teach-back methodology that includes basic health literacy and empathetic communication will be provided.

SECTION V

PICO Statement

Improve the communication of nurses following Teach-Back education.

P: Staff nurses on a medicine unit at an academic medical center

I: Teach-Back Education

C: No education

O: Improve nurse communication skills on the Health Professionals

Communication Skills scale and the Communication with Nurses domain on the Press Ganey Survey, specifically the question “nurses explain in a way you could understand”.

T: March 2018

SECTION VI

Project Proposal

Purpose

The purpose of this project was to improve nurse communication skills and facilitate patient understanding of care. An educational program was implemented to improve patient understanding of important healthcare instructions using the teach-back technique. Outcome measures included survey responses to the question, “the nurse explains in a way you understand” on HCAHPS survey.

Design

This project was designed to implement an education module on health literacy and the teach-back technique and to compare pre and post-surveys. HCAHPS scores were compared, as well as data collected from The Health Professionals Communication Skills Scale, an 18-item survey measuring empathy, informative communication, respect and social skills (See Appendix A). The survey is scored with a Likert Scale with choices of (a) almost never, (b) once in a while, (c) sometimes, (d) normally, (e) very often, and (f) many times. This is a relatively new survey and a Confirmatory Factor Analysis (CFA) revealed that items in the 18-item survey had factor loadings greater than .40 except for social skills (.35); however, all were a good fit. Internal consistency (Cronbach’s α) of each dimension was greater than .70 except for social skills at .65 with a 95% confidence interval, and a goodness of fit (Leal-Costa, Tirado-Gonza’lez, Rodriguez-Marin, & vander-Hostadt-Roma’n, 2015). Permission to use the survey was given by Ce’sar Leal-Costa.

Setting

A 14-bed adult hospitalist medicine unit in an academic medical center was utilized for this project.

Subjects Selection Criteria

The sample was 13 registered nurses, including weekend and night staff, on the 14-bed adult hospitalist medicine unit. Those nurses on leave of absence were excluded from the project.

Interventions and Interactions

All RN staff on 9NT were invited to attend a mandatory one-hour Communication Class where the teach-back method was taught by the project manager (see Appendix B) for the education plan). Teach-back includes giving information that is (a) personalized, (b) need to know, (c) jargon-free, and (d) in three to five manageable chunks at each encounter. Teach-back is one method to ensure patients' understanding of oral information regardless of health literacy. The one-hour communication class was to be offered over two to four weeks until all registered nurses not on Leave of Absence had attended. Nurses were also instructed to document teach-back in the electronic medical record. Following the class, during the first two weeks of implementation of teach-back, the project manager will meet with staff to discuss successes, challenges, and barriers.

Prior to the class and six weeks after the last class, an e-mail was sent to all nurses on 9NT to complete the Health Professionals Communication Skills Scale (HP-CSS) online. Charge nurses received a printed flyer to share during daily shift change safety huddle, asking staff to complete the survey. The online survey completes with a custom thank you instructing nurses to print that page or take a picture and give to the Unit

Manager in exchange for the \$10.00 gift card. A reminder email was planned for 9N staff at two weeks and again at four weeks, if necessary.

Outcome Measure(s)

1. Press Ganey scores for *Communication with Nurses*, specifically the question “nurses explain in a way you could understand”, were evaluated by discharge date for three months post education.
2. The Health Professionals Communication Skills Scale (HP-CSS) was used to assess nurses’ perception of their communication skills before and after education. The survey was given immediately before class and six weeks after the class has concluded. Nurses can receive a \$10.00 gift card upon completion of the second survey.

Analytical Plan

Results will be analyzed using descriptive statistics.

Human Subjects Protection

Prior to class an e-mail was sent to staff notifying them of the mandatory class and inviting them to participate in an online communication survey. At the beginning of the class, nurses were informed of the project including the option of completing, pre and post-surveys. Nurses were offered an opportunity to complete the survey prior to class starting. Completion of the online survey indicated consent.

No demographic information was collected; all nurse surveys were completely anonymous. All nursing staff received an email with the survey link reminding to complete the pre-survey and the post-survey at six weeks. Data was kept in a locked cabinet in a locked office. Analysis was done on a password protected computer. Only

the investigators and the faculty advisor had access to raw data. No reference to any individual participant will appear in reports, presentations, or publications that may arise from the study. The University faculty will dispose of raw data in three years according to their policy.

Subject Recruitment Methods

Nurses on the hospitalist unit were required to attend a communication class that included the teach-back method. Staff was informed of the upcoming communication classes one week prior to implementation of the project during change of shift huddles. During the weeks of the education, the Charge Nurse assigned nurses to attend during work hours.

Informed Consent

Participants were fully informed of the project plan. Completion of the online survey indicated consent.

Confidentiality and Privacy

Data access was limited to study staff. Data and records were kept locked and secured, with any computer data password protected. No reference to any individual participant will appear in reports, presentations, or publications that may arise from the study. The University will store all raw data for three years and then destroy according to policy.

SECTION VII

Project Implementation

The project was implemented following Institutional Review Board (IRB) approvals from the facility and the University. The classes were designed to include information on health literacy and teach-back. Staff nurses on this unit frequently discuss a lack of knowledge of how to communicate effectively with patients with addiction issues, so a small segment on empathetic communication was added to the educational offering. All staff nurses (13) on the Hospitalist medicine unit were informed of the required class via shift huddles, unit rounds by the Educator, and during a staff meeting by the Interim Unit Manager. Five classes were scheduled on three dates from December 4 to December 9th; one-hour before and one-hour after shift change, during a period when it was typically less busy during the middle of the day shift, and a Saturday morning, to allow staff nurses several opportunities for attendance.

The first class was held December 4 with the project manager arriving one hour prior to the class, to round on the unit and remind staff of the upcoming class, and staying for 30 minutes after each class, to allow staff an opportunity to attend if the shift was busy. Of the 13 nurses working on the unit, one attended the first class, and two more attended another class, for a total of three. A discussion with the Interim Manager, following the last class, resulted in additional mandatory classes scheduled for the next month (January). The manager assigned the remaining nurses (10) to attend a specific class during their shift and arranged for patient coverage during that time. Of the 10 remaining nurses, seven attended; the three scheduled for the weekend class were unable

to attend due to patient acuity, and it was decided to forego scheduling of any additional classes.

The classes were designed to provide opportunities for staff engagement; nurses were asked at the beginning of the class to write on a card (a) five simple pleasures they most enjoy (b) a travel destination on their bucket list, (c) the most important person in their lives who didn't live with them, and (d) the three most pressing things, not work related, on their to-do list. As the presentation progressed, each of the items on the list were discussed in relation to either the nurse or their family member being admitted to the hospital and its impact. For example, when discussing their simple pleasures, the project manager asked each nurse to give their card to the person next to them and to ask that person to delete two things off the list then give it back to the owner. The project manager then asked the nurses to imagine they had been unexpectedly admitted to the hospital and how it felt to lose those simple pleasures. There was a brief discussion on the impact of the loss, and staff were reminded that patients experience this when admitted to a medicine unit. For each of the items listed on their card, a similar activity and brief discussion was held, with participation from all participants during each class. The verbal response to the class was positive; however, a formal summative evaluation of the class was not done.

The original plan was to observe nurses for two weeks following the completion of the last class; however, there were delays due to weather. There were major snow storms and below freezing temperatures, which affected hospital staffing, and thus observations were delayed. The project manager had pre-arranged out of town

commitments, coinciding with these two weeks, so the follow-up visits occurred during the fourth and fifth week after the last class (January 29th and February 5).

Staff nurses were observed during patient contact, and often the interactions were nursing care activities i.e., dressing changes, and administering medications. These demonstrated the caring behaviors identified by Fakhr-Movahedi et al. (2016) and Watson (2008). Patients were treated with respect and caring, and questions were answered. Many of the patients were several days into the dressing change, and it was apparent the patient understood the procedure.

During one observation, the patient expressed a desire to leave Against Medical Advice (AMA) because he was not making money while in the hospital. This patient was hospitalized for seven days of intravenous fluid. The nurse was solicitous and caring but did not ask questions to further identify patient needs that could have been provided by other disciplines, i.e., social worker or chaplain services. After leaving the room, when asked the occupation of the patient, the nurse replied, she didn't know. This offered an opportunity to discuss developing relationships with patients and ascertaining information to act as an advocate. This nurse was reminded that one should fully explore the meaning of the hospital experience with the patient and family, offering opportunities to advocate and assist with discharge needs.

The nurse observed performing an admission assessment prior to the project was observed again in the post-intervention period. She was able to clearly explain to the patient the new television system, she asked the patient to demonstrate techniques she gave instructions for during the room orientation, and she ensured the patient had a clear

understanding of what was to come next in her plan of care. This was a vast improvement from the previous shadowing experience.

Nurses were asked what information they had incorporated into their practice following the classes. Many stated they now gave patients specific information on the time of the next medication when doing a discharge. Another staff nurse stated that she facilitated patients' understanding of their treatment plan by using the white-board in the room to write information pertinent to the patient and family members, i.e., tests, treatments, and results of daily labs needing to trend in a certain direction before discharge was possible. Nurses were able to discuss patients who they labeled difficult, and their attempts to communicate empathetically. When specifically asked about teach-back, many stated they were not consistently using the communication method.

Project Challenges

The first major challenge to the project was the elimination of the project manager's position within the organization. Since this is an academic medical center, permission was given to work on the project once all of the student requirements were met for the organization. The inability to have continuity with the staff was a challenge once the project manager was no longer an employee.

During the planning of this project, the hospitalist medical unit was part of a larger 32-bed unit; 14 beds on one end of the hall and 28 beds on the other end separated by fire doors. The staff floated between the two, so all staff would have participated in the education. At the time of the position elimination, the smaller 14-bed unit was closed due to lack of staff with an intention of opening again as a completely separate unit with dedicated staff. When the unit re-opened, there were 13 staff nurses working on the unit

with only five of the nurses known to the project manager; many with less than two years' experience. The project manager spent time on the unit with the staff, but this was awkward, as the only reason for being there was to get to know people who were busy working. In addition, by the time the classes took place, there were only 12 full time staff remaining, with several open positions.

Although the interim manager stated the classes were mandatory, only three staff attended, not enough to make a difference in patient outcomes, thus necessitating more classes, which were not held until the following month. The southeast region of the U.S does not typically get snow and subfreezing weather; however, both occurred during the month the classes were completed. When it snows in this area, everything is delayed, and staff is focused on the weather and trying to have enough staff to take care of patients. This was not an appropriate time to shadow; therefore, all of the shadowing experiences were scheduled four weeks after the classes.

Post-education shadowing began after the first med pass as requested by several staff members, as this time was most busy with bedside shift report and preparing for the shift. The project manager shadowed nurses during a variety of times to capture different communication interaction; however, it did not necessarily coincide with a variety of experiences. In addition, the project investigator never felt the staff trusted her enough to be themselves, so they may have been on their best behavior.

Project Positives

Even though there were only three nurses during the initial classes, a total of 10 attended out of the 13 staff for a 76.9% attendance rate. Fortunately, all three of those who did not attend were day shift staff nurses and the project manager spent time with

them during the observation weeks to speak about teach-back. The newly hired Unit Manager spoke with the project manager on the last day of observation and asked for feedback. She stated she would follow up with staff on teach-back implementation on that unit. In addition, she stated she would share with them the HCAHPS data as it became available. Finally, the hospital implemented a teach-back initiative for the nursing staff in March, the final month of monitoring for this project. Staff was required to complete an online module on health literacy and teach-back.

SECTION VIII

Interpretation of Data

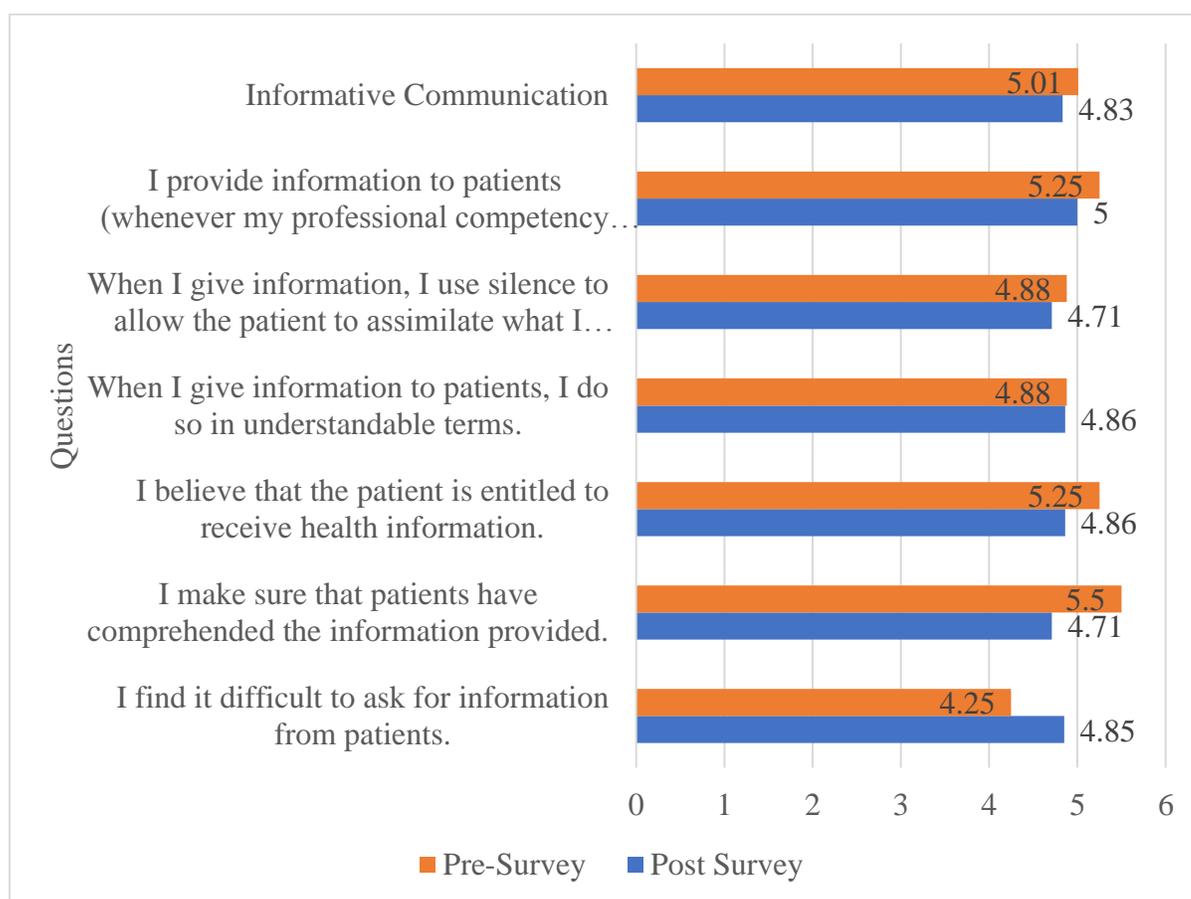
Results

HP-CSS Results

To measure nurse's communication skills, The Health Professionals Communication Skills Scale (HP-CSS), an 18-item survey measuring empathy (five questions), informative communication (five questions), respect (three questions) and social skills (four questions) was used. Permission was granted by survey developers. The four dimensions were intermingled throughout the survey. Empathy questions measured health professional's ability to comprehend the feelings of patients and demonstrate empathetic behaviors, i.e., active listening, and empathetic responses in the intrapersonal relationships. Informative communication is the manner health professionals provide and obtain information in the relationship. Respect includes the authenticity demonstrated in the relationship, and social skills are the ability to be assertive and exhibit socially skillful behaviors relationship (Leal-Costa et al., 2016; Watson, 2008). The survey is scored on a Likert Scale with choices of (a) almost never, (b) once in a while, (c) sometimes, (d) normally, (e) very often, and (f) many times. Two questions were inversely worded and were analyzed appropriately.

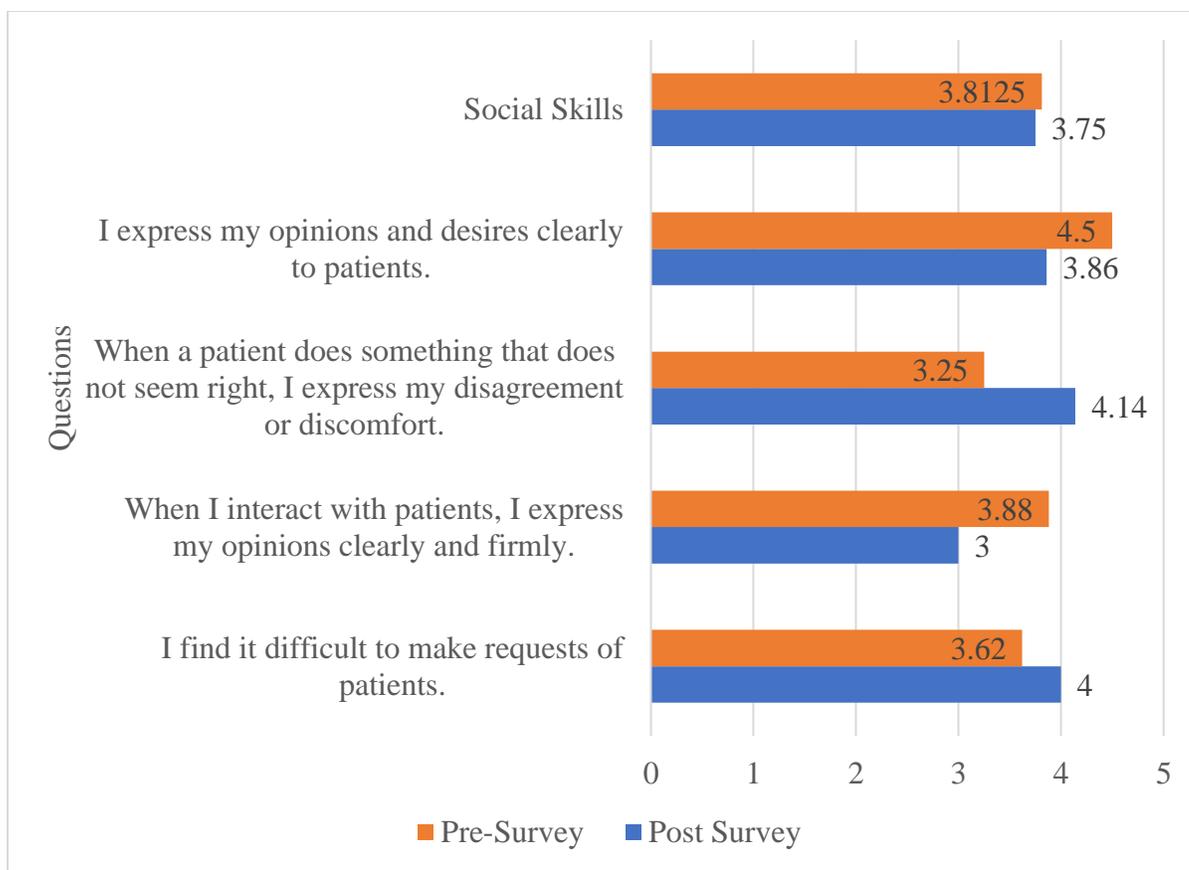
Of the 13 nurses working on the hospitalist medicine unit prior to the class, eight ($N=8$; 61.5%) completed the survey, and seven of the 14 staff ($N=7$; 50%) working on the unit at the end of the project completed the post-survey. The Quickcalcs unpaired t -test descriptive analysis program was used to determine the difference between pre and post-surveys for each of the four dimensions. Prior to analysis, the questions were rearranged

to reflect results per dimension. Overall, the post-survey responses were lower than the pre-survey responses in each domain. The aggregate mean score for informative communication decreased from 5.01 to 4.83 ($p=0.37$) and social skills decreased from 3.81 to 3.75 ($p=0.87$) on the post-survey, while the aggregate mean score for respect decreased from 5.46 to 4.76 ($p<.05$) and empathy from 5.32 to 4.77 ($p<.05$) post-survey. Figures 4 - 7 report the pre and post-survey aggregate means and means for each question in the subscale.



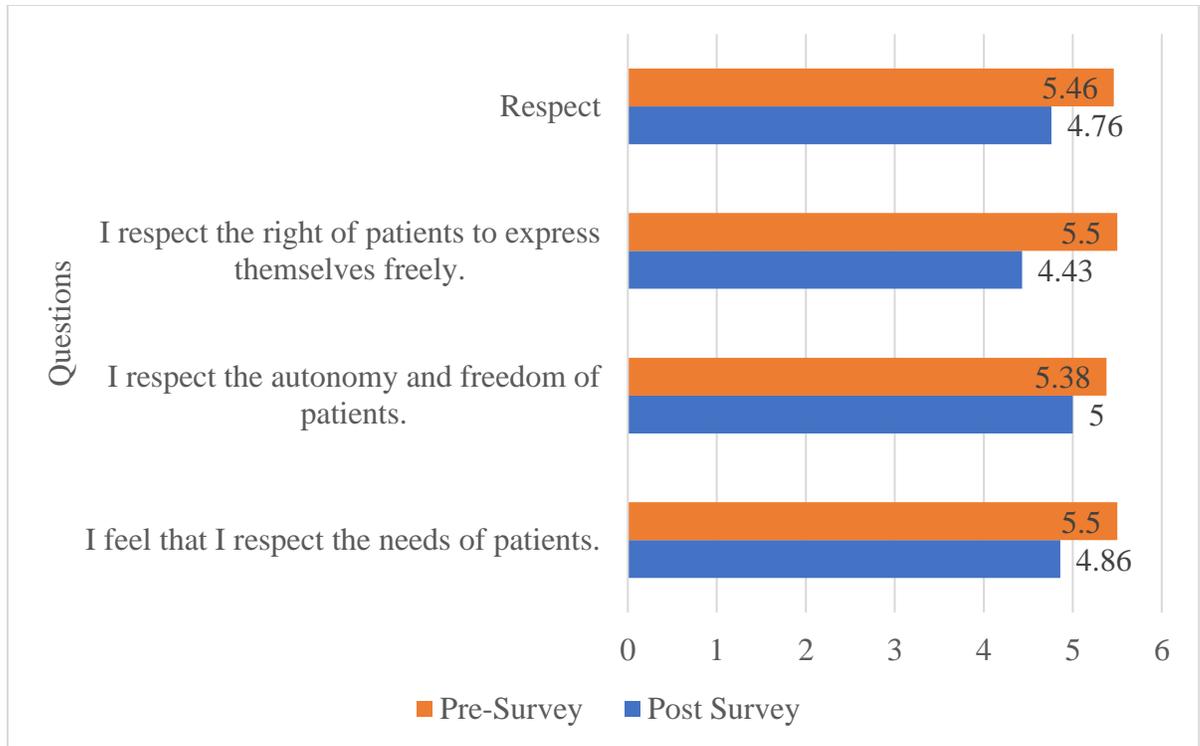
Note. $t=0.9192$; $df=10$; $p=0.3796$;

Figure 4. Informative Communication Pre and Post-Survey Results



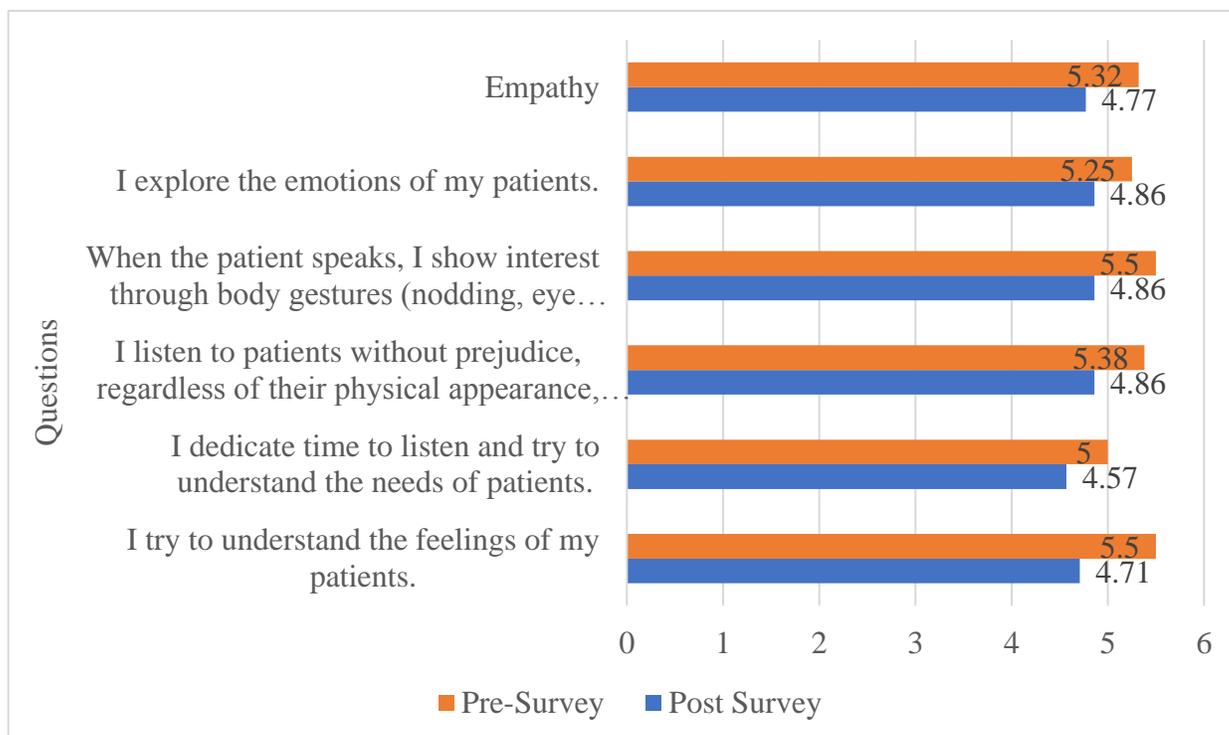
Note. $t=0.1701$; $df=6$; $p=0.8705$

Figure 5. Social Skills Pre and Post-Survey Results



Note. $t=3.9561$; $df=4$; $p<.05$;

Figure 6. Respect Pre and Post-Survey Results



Note. $t=5.0219$; $df=8$, $p<.05$

Figure 7. Empathy Pre and Post-Survey Results

HCAHPS Results

The hospitalist medical unit selected for this project has 14-beds, with a budgeted staff of 16 Registered Nurses; however, at the time of this project, there were 13. All patients discharged home receive the HCAHPS survey with an average response rate of approximately 12%. During the pre-survey period (September – November) 22 patients completed the survey and during the post-survey period (January-March) only three patients completed the survey. Figure 8 reveals the pre and post survey results; the N represents the total number of respondents and the percentage selecting the *always* response.

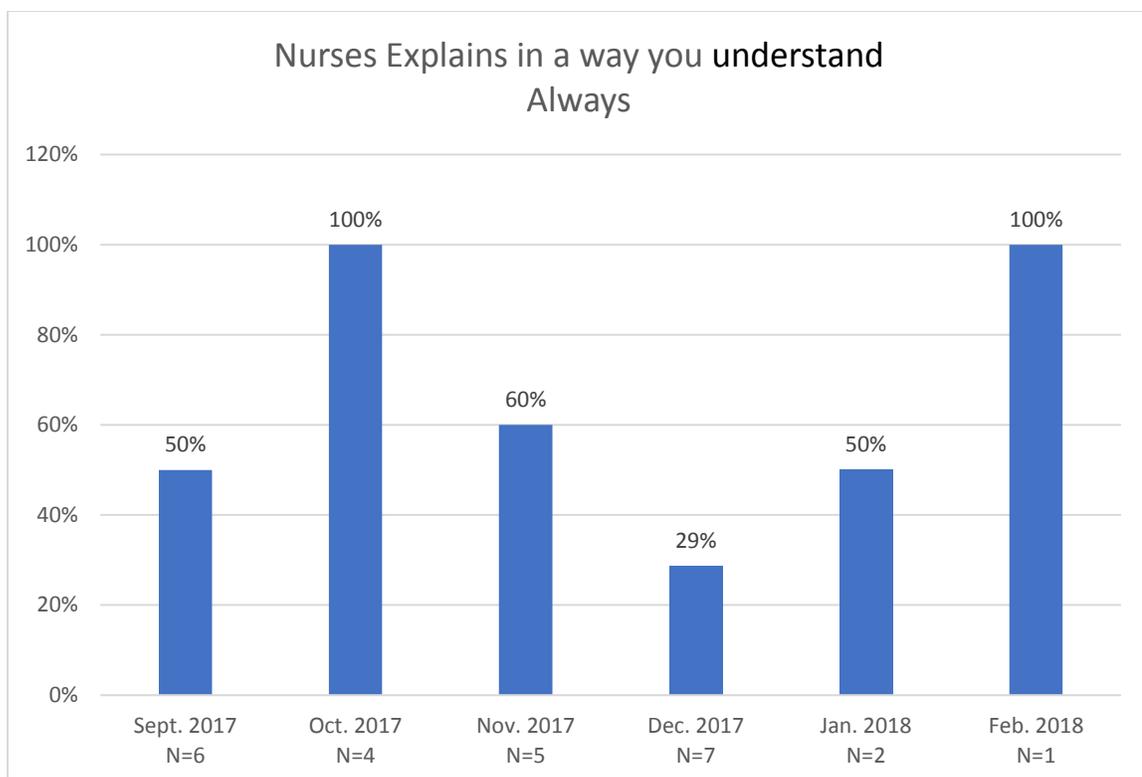


Figure 8. Pre and Post HCAHPS Survey Results

Discussion

This project was implemented to improve the patient experience by enhancing nurse-patient communication. A one-hour class incorporating health literacy and its effect on patient understanding, how to communicate empathetically, and demonstrations of the teach-back technique was provided. Staff participated in a pre and post HP-CSS survey which measured communication skills in the dimensions of informative communication, social skills, respect, and empathy. The aggregate mean responses by the participating staff nurses decreased in all the dimensions. At the close of this project, there were not enough HCAHPS surveys returned to determine outcomes.

The purpose of this project was to provide education for nurses in an effort to improve their communication techniques and patient interactions by using the teach-back method, each of which required the nurse to incorporate a new habit. Nilsen, Roback, Brostrom, and Ellstrom (2012) suggested that one should account for personal habits when a behavior change is desired. The authors further state that a change in behavior will only occur if there is a “positive attitude and a strong intention to modify” (p. 4). Additionally, a habit is developed when the behavior becomes automatic. One factor that may have negatively impacted the development of a teach-back habit by staff on this unit was multiple unit changes. During the implementation of the project, the unit was divided into two, a 14-bed unit and a 28-bed unit. The nurses on the unit were also divided and assigned to one unit with many of the less experienced nurses assigned to pilot unit (14-bed). Additionally, the project was implemented between Thanksgiving and Christmas holidays with an interim unit manager. When a permanent manager was hired for the unit, she agreed that teach-back was a best practice she wanted staff to use with patients. In March, two months following the original education plan, a health literacy and teach-back module, developed in collaboration with the project manager and placed in the organization’s learning management system (LMS) as a pilot for a few units, was released to the rest of the organization. The nurse manager stated she would help to sustain the project by working with staff to continue the practice of using teach-back with patients and monitor HCAHPS for trends.

Limitations

The timing of the project coincided with a change in organizational leadership and unit structure. The project manager was laid off before the project was implemented. The

unit manager who was a major stakeholder in the DNP project, resigned his position and an interim manager, who had responsibility for two other units, was appointed. By the completion of the project, a permanent manager was hired. When the project was approved by the director of medicine, the unit was 34-beds on one floor with two nurses stations, and a fire door separating the two. When the project began, the units had been split into two, with 14-beds on one end and 28 beds on the other. The smaller unit was budgeted for 16 FTE; however, there were only 13 full-time staff at the beginning of the project. Most of the staff nurses had less than two years' experience. It was not possible to interpret the HCAHPS scores for the question "the nurse explains in a way you understand" because of the small number of survey returns (N=3).

Future Recommendation/Sustainability

The manager of the unit is committed to continuing the teach-back method to improve communication and understanding between patients and nursing staff. The unit educators should encourage preceptors to role model the teach-back method for new staff. Additionally, the teach-back module should be placed on the new employee orientation competency sheet and included in annual competencies for all staff on this unit. The organization has recently implemented a Medical-Surgical Academy with communication as one of its foci. Role-playing teach-back with staff during the Academy classes could facilitate the development of teach-back as a habit.

Lesson Learned

This project has facilitated the translation of the DNP Essentials into practice (American Association of Colleges of Nursing [AACN], 2006). Two primary essentials that guided this project was: II. Organizational and Systems Leadership for Quality and

VI. Interprofessional Collaboration for Improving Patient and Population Health

Outcomes. Patient satisfaction with care is a driver of health care cost and reimbursements, and as a DNP student, it was imperative to identify a project to help meet organizational goals. This project provided an opportunity to improve organizational outcomes by doing a needs assessment and focusing on priority concerns of administrators, staff, and patients.

This project manager met with senior leadership of the Medicine Division to collaborate on a practice area with the highest need. These discussions offered the project manager an opportunity to negotiate a best practice solution, including educational content, length of class, and most opportune times. Skills learned were negotiation, persuasion, and the interconnectedness of organizations. When determining the content for the class, senior leadership identified several educational programs currently in place and gave the project manager an opportunity to experience those as a student and as a facilitator. Knowing what communication skills were being taught to other department employees helped this project manager to identify and clarify the need for a class that included the teach-back method for improved communication between patients and nurses.

Conclusion

Numerous studies have identified the teach-back method as an effective strategy in healthcare provider-patient communication (AHRQ, 2017; Centrella-Nigro & Alexander, 2017; Green et al., 2015; Peter et al., 2015). Staff on this medicine hospitalist unit were required to attend a communication class where the teach-back method was taught. Staff voluntarily completed a pre and post HP-CSS staff survey which measured

communication skills in the dimensions of informative communication, social skills, respect, and empathy. There were no improvements as measured by the staff survey four weeks following the education and a poor patient response rate resulted in immeasurable outcomes for patient perception of improved communication. At this time, the organization has implemented the teach-back method of communication for all staff including newly hired nurses. A teach-back module had been placed in the electronic learning management system for mandatory completion by all staff. With this multi-level approach to implementing teach-back, patients should have greater opportunities for understanding their care.

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Appendix A

Health Professionals Communication Skills Scale, HP-CSS[®]

Read each question and check the response that best describes your experience.

	Almost never	Once in a while	Sometimes	Normally	Very often	Many times
1. I respect the right of patients to express themselves freely.	<input type="checkbox"/>					
2. I explore the emotions of my patients.	<input type="checkbox"/>					
3. I respect the autonomy and freedom of patients.	<input type="checkbox"/>					
4. When the patient speaks, I show interest through body gestures (nodding, eye contact, smiles, ...).	<input type="checkbox"/>					
5. I provide information to patients (whenever my professional competency permits me) about what concerns them.	<input type="checkbox"/>					
6. I listen to patients without prejudice, regardless of their physical appearance, mannerisms, form of expression, ...	<input type="checkbox"/>					
7. I express my opinions and desires clearly to patients.	<input type="checkbox"/>					
8. When I give information, I use silence to allow the patient to assimilate what I am saying.	<input type="checkbox"/>					
9. When I give information to patients, I do so in understandable terms.	<input type="checkbox"/>					
10. When a patient does something that does not seem right, I express my disagreement or discomfort.	<input type="checkbox"/>					
11. I dedicate time to listen and try to understand the needs of patients.	<input type="checkbox"/>					
12. I try to understand the feelings of my patient.	<input type="checkbox"/>					
13. When I interact with patients, I express my opinions clearly and firmly.	<input type="checkbox"/>					
14. I believe that the patient is entitled to receive health information.	<input type="checkbox"/>					
15. I feel that I respect the needs of patients.	<input type="checkbox"/>					
16. I find it difficult to make requests of patients.	<input type="checkbox"/>					
17. I make sure that patients have comprehended the information provided.	<input type="checkbox"/>					
18. I find it difficult to ask for information from patients.	<input type="checkbox"/>					

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Appendix B

Communication Skills Education Plan

Title of Activity: Communication

Identified Gap(s): Nursing communication skills

Learning Outcome (s): <u>Use Teach-back when communicating need to know information to patients/families</u> Select all that apply: <input type="checkbox"/> Nursing Professional Development <input type="checkbox"/> Patient Outcome <input type="checkbox"/> Other: Describe _____				
Objectives	CONTENT (Topics)	TIME FRAME (if live)	PRESENTER/ AUTHOR	TEACHING METHODS/LEARNER ENGAGEMENT STRATEGIES
List the learner's objectives in behavioral terms	Provide an outline of the content	Approximate time required for content	List the Author	List the learner engagement strategies to be used by Faculty, Presenters, Authors
Discuss the impact of health literacy on patient outcomes	Define Health Literacy Discuss tests for health literacy	10 minutes	Sheila Smallwood	Power Point Discussion
Use an empathetic response to a patient scenario	Discuss empathy and its relevance to patients and families Practice empathetic responses	15 minutes	Sheila Smallwood	Brene' Brown You Tube video Role Play
Describe teach-back	Define Teach-back	5 minutes	Sheila Smallwood	Power Point
List the components of teach-back	Personalized Need to know Jargon-free Three to five manageable chunks at a time	10 minutes	Sheila Smallwood	Power Point
Demonstrate teach-back	Role Play teach-back	15 minutes	Sheila Smallwood	Scenarios Role Play

Description of current state: The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) score for *communication with nurses* within the organization is 79%, yet the medicine division scores are 66%. *Nurses Explain in a way you understand* is 64%.

Description of desired/achievable state: Improve nurse communication skills and facilitate patient understanding of care.

Gap to be addressed by this activity: Knowledge Skills Practice
 Other: Describe _____